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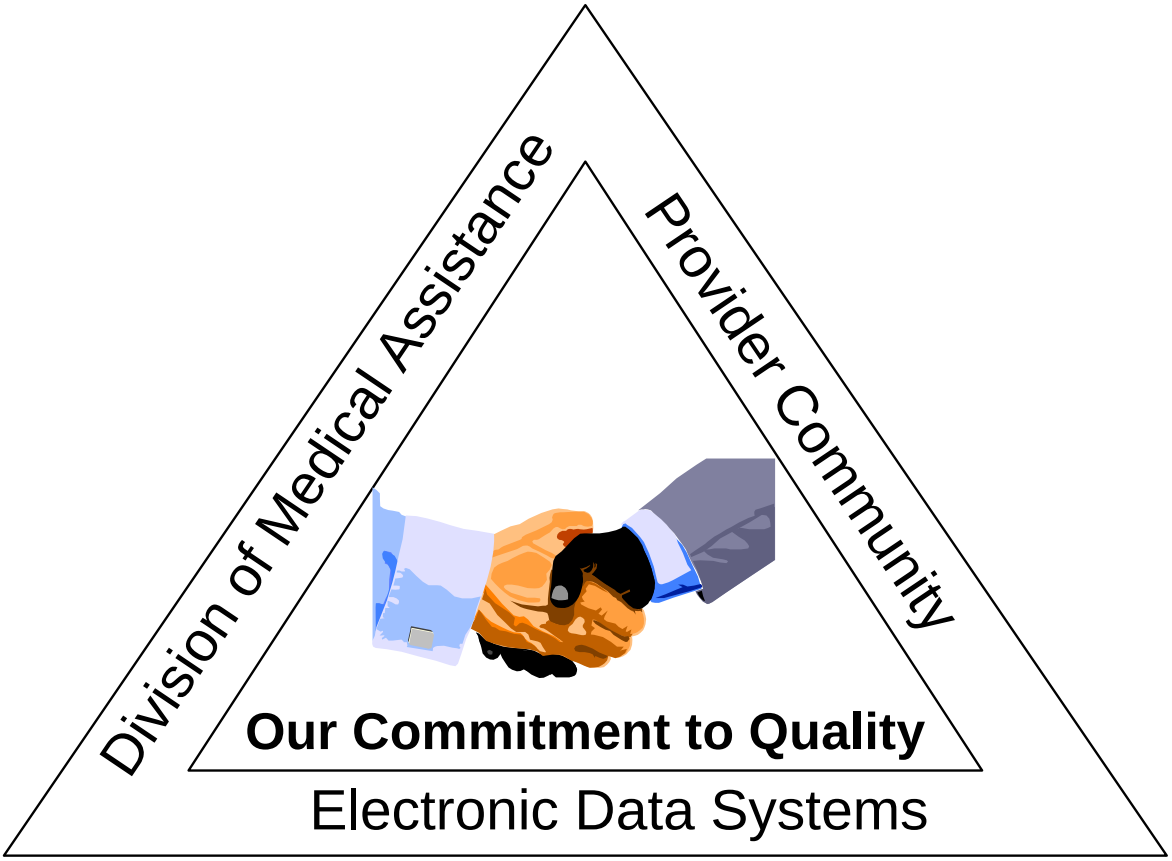
Attention:
All Health Check Providers

Effective July 1, 2003

Health Check
Billing Guide
2003

COMMITMENT TO QUALITY

EDS and DMA share a common goal with the provider community to ensure quality health care is provided to all North Carolina Medicaid recipients in the most efficient and economical manner.



Quality is the process of delivering products and services that meet our customers' requirements and exceed their expectations to generate customer satisfaction and success.

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Effective with claims processed on or after July 1, 2003, several changes have been made to the Health Check Program. These changes are outlined in this special bulletin. Please replace the July 2002 Special Bulletin IV, *Health Check Billing Guide 2002* with this special bulletin. For your convenience, shading indicates new information

DMA and EDS continue the effort to comply with HIPAA requirements. Effective August 1, 2003, the N.C. Medicaid program will begin accepting the ASC X12N 837 Health Care Claim Professional transaction. The current N.C. Medicaid electronic formats will continue to be accepted until October 16, 2003.

HEALTH CHECK SCREENING COMPONENTS

The Health Check Program is a preventive care program for Medicaid-eligible children ages birth through 20. **A Health Check screening is the only well child preventive visit reimbursable by Medicaid**. **All Health Check components are required and are to be documented in the patient's medical record. Each screening component is vital for measuring a child's physical, mental, and developmental growth.** Recipients are encouraged to receive their comprehensive health checkups and immunizations on a regular schedule. A complete Health Check screening consists of the following age-appropriate components, which must be performed and documented at each visit **unless** otherwise noted.

- **Comprehensive unclothed physical examination**

- **Comprehensive health history**

- **Nutritional assessment**

- **Anticipatory guidance and health education**

- **Measurements, blood pressure, and vital signs**
  Blood pressure is required to become a part of the exam at age 3.

- **Developmental screening including mental, emotional, and behavioral**
  Perform age-appropriate evaluation at **each** screening. In addition, three written developmental assessments should be performed: the first by 12 months, the second by 24 months, and the third by 60 months of age.

- **Immunizations**
  Federal regulations state that immunizations are to be provided at the time of screening if they are needed.

- **Vision and hearing assessments**
  Health Check follows the Recommendations for Preventive Pediatric Health Care from the American Academy of Pediatrics for hearing and vision assessments. The Recommendations for all screening components may be accessed at http://www.aap.org/policy/re9939.html.

  In accordance with the periodicity schedule and the Recommendations for Preventive Pediatric Health Care, **objective** vision assessment (i.e., Snellen chart) is required at ages 3 years, 4 years, 5 years, 6 years, 9 years, 12 years, 15 years, and 18 years.

  In accordance with the periodicity schedule and the Recommendations for Preventive Pediatric Health Care, objective hearing assessments **using electronic equipment** (i.e., audiometer) must be performed at birth, 4 years, 5 years, 6 years, 9 years, 12 years, 15 years, and 18 years.

If the required vision and/or hearing screenings cannot be performed during a periodic visit due to blindness or deafness and the claim is denied, the claim may be resubmitted through the adjustment process with supporting medical record documentation attached.

- **Dental screenings**
  A dental referral is required for every child beginning at 3 years of age. An oral screening performed during a physical examination is not a substitute for examination through direct referral to a dentist. The initial dental referral must be provided regardless of the periodicity schedule unless it is known that the child is already receiving dental care. Thereafter, dental referrals should, at a minimum, conform to the dental service periodicity schedule, which is currently one routine dental examination every six months. When any screening indicates a need for dental services at an earlier age (i.e., baby bottle caries), referrals must be made for needed dental services and documented in the patient's record. The periodicity schedule for dental examinations is not governed by the schedule for regular health screenings.

  Note: Dental varnishing is not a requirement of the Health Check screening exam. Providers may bill for dental varnishing and receive reimbursement in addition to the Health Check screening. Providers are to utilize the codes and billing guidelines indicated in the August 2002 general Medicaid bulletin. Bulletins are available on the Division of Medical Assistance (DMA) website at http://www.dhhs.state.nc.us/dma.

- **Laboratory procedures**
  Includes hemoglobin or hematocrit, urinalysis, sickle cell, tuberculin skin test, and lead screening.

  Note: When these laboratory tests are processed in the provider's office, Medicaid will not reimburse separately for these procedures. Payment for these procedures is included in the reimbursement for a Health Check screening.

  Hemoglobin or hematocrit
  Hemoglobin or hematocrit must be measured once during infancy (between the ages of 9 and 12 months) for all children and once during adolescence for menstruating adolescent females. An annual hemoglobin or hematocrit screening for adolescent females (ages 11 to 21 years) must be performed if any of the following risk factors are present: moderate to heavy menses, chronic weight loss, nutritional deficit or athletic activity.

  The Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) has specific guidelines for hematocrit/hemoglobin testing. Sharing the test results between the WIC Program and the primary care provider (PCP) is encouraged with appropriate release of information. For more information on guidelines and time frames, call the local WIC office.

  Urinalysis
  Urinalysis must be performed during the 5-year-old periodic screening as well as during periodic screenings for all sexually active males and females.

  Sickle cell testing
  North Carolina hospitals are required to screen all newborns for sickle cell prior to discharge. If a child has been properly tested, this test need not be repeated. **Results must be documented in the child's medical record.** If the test results of the newborn sickle cell screening are not readily available, contact the hospital of birth. An infant not tested at birth should receive a sickle cell test prior to 3 months of age.

Laboratory procedures, continued

Tuberculin testing
Reviewing perinatal histories, family and personal medical histories, significant events in life, and other components of the social history will identify children/adolescents for whom TB screening is indicated. If none of the screening criteria below are present, there is no recommendation for routine TB screening.

The North Carolina TB Control Branch is responsible for oversight of testing of household and other close contacts of active cases of pulmonary and laryngeal tuberculosis. Questions related to policy interpretation or other questions related to TB skin testing should be directed to the local health departments.

Tuberculin testing should be performed as clinically indicated for children/adolescents at increased risk of exposure to tuberculosis, **via Purified Protein Derivative (PPD) intradermal injection/Mantoux method** – not Tine Test.

Criteria for screening children/adolescents for TB (per the NC TB Control Branch) are:

1. Children/adolescents reasonably suspected of having tuberculosis disease based on clinical symptoms.

2. Do a **baseline screen** when these children/adolescents present for care.

    a. Foreign-born individuals arriving within the last five years from Asia, Africa, Caribbean, Latin America, Mexico, South America, Pacific Islands, the Middle East or Eastern Europe. Low prevalence countries for tuberculosis disease are the USA, Canada, Japan, Australia, New Zealand, and countries in Western Europe.

    b. Children/adolescents who are migrants, seasonal farm workers, or are homeless.

    c. Children/adolescents who are HIV-infected.

    d. Children/adolescents who inject illicit drugs or use crack cocaine.

Subsequent TB skin testing is not necessary unless there is a continuing risk of exposure to persons with tuberculosis disease.

In addition to the TB Control Branch criteria:
A TB screening performed as a part of a Health Check screening cannot be billed separately.

Laboratory procedures, continued

Lead screening

Federal regulations state that all Medicaid-enrolled children are required to have a blood lead test at 12 and 24 months of age. Children between 36 and 72 months of age must be tested if they have not been previously tested. Providers should perform a lead screening when it is clinically indicated.

Medical follow-up begins with a blood lead level greater than or equal to 10 ug/dL. Capillary blood level samples are adequate for the initial screening test. Venous blood level samples should be collected for confirmation of all elevated blood lead results.

Blood Lead Concentration	Recommended Response
<10 ug/dL	**Rescreen at 24 months of age**
10 to 19 ug/dL	**Confirmation (venous) testing should be conducted within three months.** If confirmed, repeat testing should be conducted every 2 to 4 months until the level is shown to be <10 ug/dL on three consecutive tests (venous or fingerstick). The family should receive lead education and nutrition counseling. A detailed environmental history should be taken to identify any obvious sources of exposure. If the blood lead level is confirmed at ≥10 ug/dL, environmental investigation will be offered.
20 to 44 ug/dL	**Confirmation (venous) testing should be conducted within 1 week.** If confirmed, the child should be referred for medical evaluation and should continue to be retested every 2 months until the blood lead level is shown to be <10 ug/dL on three consecutive tests (venous or fingerstick). Environmental investigations are required and remediation for identified lead hazards shall occur for all children less than 6 years old with confirmed blood lead levels >20 ug/dL.
≥45 ug/dL	**The child should receive a venous lead test for confirmation as soon as possible**. If confirmed, the child must receive urgent medical and environmental follow-up. Chelation therapy should be administered to children with blood lead levels in this range. Symptomatic lead poisoning or a venous lead level >70 ug/dL is a medical emergency requiring inpatient chelation therapy.

State Laboratory of Public Health for Blood Lead Screening

The State Laboratory Services of Public Health will analyze blood lead specimens for all children less than 6 years of age at no charge. Providers requiring results of specimens from children outside this age group need to contact the State Laboratory of Public Health at 919-733-3937.

HEALTH CHECK SCREENING SCHEDULES

Periodic Screenings

The **preventive medicine CPT codes 99381 through 99385 with the modifier EP, and 99391 through 99395 with the modifier EP** are used to bill a periodic screening. (Refer to Health Check Billing Requirements on page 9.)

The schedule below outlines the recommended frequency of Health Check screenings dependent upon the age of the child. This schedule is based on recommendations for preventive pediatric health care.

Note: If an illness is detected during a Health Check screening, the provider may continue with the screening or bill a sick visit and reschedule the screening for a later date.

Periodicity Schedule

Within the first month	12 months	5 years
2 months	18 months	6 through 20 years
4 months	2 years	One screening every three
6 months	3 years	years for children 6 years of
9 or 15 months	4 years	age and older.

Interperiodic Screenings

The **preventive medicine CPT codes 99381 through 99385 with the modifier EP, and 99391 through 99395 with the modifier EP** are used to bill an interperiodic screening. (Refer to Health Check Billing Requirements on page 9.)

In addition to the periodicity schedule, interperiodic screenings are allowed in the following circumstances:

- When a child requires either a kindergarten or sports physical **outside** the regular schedule.
- When a child's physical, mental or developmental illnesses or conditions have already been diagnosed and there are indications that the illness or condition may require closer monitoring.
- When the screening provider has determined there are medical indications that make it necessary to schedule additional screenings in order to determine whether a child has a physical or mental illness or a condition that may require further assessment, diagnosis or treatment.
- Upon referral by a health, developmental or educational professional based on their determination of medical necessity. Examples of referral sources may include Head Start, Agricultural Extension Services, Early Intervention Programs or Special Education Programs.

In each of these circumstances, the screening provider must specify and document in the child's medical record the reason necessitating the interperiodic screening.

Hearing and vision assessments are not required for an interperiodic screening. All other Health Check components must be performed during an interperiodic Health Check screening.

IMMUNIZATIONS

Immunization Administration CPT Codes 90471 and 90472; with the EP Modifier

Medicaid reimburses providers for the administration of immunizations to Medicaid-enrolled children, birth through 20 years of age, using the following guidelines.

Private Sector Providers

An immunization administration fee may be billed if it is the only service provided that day or if any immunizations are provided in addition to a Health Check screening or an office visit.

- Administration of one immunization is billed with the administration CPT code 90471 (one unit) with the **EP** modifier and is reimbursed at $13.71.
- Additional immunizations are billed with the administration CPT code 90472 with the **EP** modifier and are reimbursed at $13.71.

The maximum reimbursement for two or more immunizations will remain at $27.42 when using both CPT codes 90471 and 90472. The **EP** modifier must be listed next to each immunization administration CPT code entered in block 24D of the CMS-1500 claim form. Immunization procedure codes must be reported even if the immunization administration fee is not being billed. For instructions on billing an immunization administration fee, refer to the chart on page 7.

Federally Qualified Health Center (FQHC) or Rural Health Clinic (RHC) Providers

An immunization administration fee may be billed if it is the only service provided that day or if any immunizations are provided in addition to a Health Check screening. Health Check screenings and the immunization administration fees are billed under the Medicaid provider number with the "C" suffix.

- Administration of one immunization is billed with the CPT code 90471 (one unit) with the **EP** modifier and is reimbursed at $13.71.
- Additional immunizations are billed with the administration CPTcode 90472 with the **EP** modifier and are reimbursed at $13.71.

An immunization administration fee cannot be billed in conjunction with a core visit. Report the immunization given during the core visit without billing the administration fee. For instructions on billing an immunization administration fee, refer to the chart on page 7.

Local Health Department Providers

An immunization administration fee may **not** be billed if immunization(s) is provided in addition to a Health Check screening. The immunization administration CPT codes 90471 with the **EP** modifier may be billed if immunizations are the only services provided that day or if any immunizations are provided in conjunction with an **office visit**.

- Administration of one or more immunizations is billed with the CPT code 90471 (one unit) with the **EP** modifier and is reimbursed at $20.00.

The immunization administration code is reimbursed at $20.00 regardless of the number of immunizations given. Immunization procedure codes must be reported even if the immunization administration fee is not being billed. For instructions on how to bill an immunization administration fee, refer to the chart on page 7.

Immunizations, continued

Billing Guidelines for Immunizations

Provider Type	Health Check Screening with Immunization(s)	Immunization(s) Only	Office Visit with Immunization(s)	Core Visit with Immunization(s)
Private Sector Providers	For one immunization, bill 90471 with the EP modifier. For additional immunizations, bill 90472 with the EP modifier. Immunization diagnosis code **not** required. Immunization procedure code(s) are required.	For one immunization, bill 90471 with the EP modifier. For additional immunizations, bill 90472 with the EP modifier. One immunization diagnosis code is required. Immunization procedure code(s) are required.	For one immunization, bill 90471 with the EP modifier. For additional immunizations, bill 90472 with the EP modifier. Immunization diagnosis code **not** required. Immunization procedure code(s) are required.	N/A
FQHC/RHC	For one immunization, bill 90471 with the EP modifier. For additional immunizations, bill 90472 with the EP modifier. Immunization diagnosis code **not** required. Immunization procedure code(s) are required.	For one immunization, bill 90471 with the EP modifier. For additional immunizations, bill 90472 with the EP modifier. One immunization diagnosis code is required. Immunization procedure code(s) are required.	N/A	Cannot bill 90471 or 90472. Immunization diagnosis code is **not** required. Immunization procedure code(s) are required.
Local Health Department Providers	Cannot bill 90471. Must report immunizations. Immunization diagnosis code **not** required. Immunization procedure code(s) are required.	For one or more immunizations, bill 90471 with the EP modifier. One immunization diagnosis code is required. Immunization procedure code(s) are required.	For one or more immunizations, bill 90471 with the EP modifier. Immunization diagnosis code is **not** required. Immunization procedure code(s) are required.	N/A

Immunization procedure code(s) must be listed in block 24D of the CMS-1500 claim form for all immunizations administered.

Universal Childhood Vaccine Distribution Program/Vaccines for Children Program

The Universal Childhood Vaccine Distribution Program (UCVDP)/Vaccines for Children (VFC) Program provides at no charge all required (and some recommended) vaccines to North Carolina children birth through 18 years of age according to the recommendations of the Advisory Committee of Immunization Practices (ACIP) of the Centers for Disease Control (CDC). Due to the availability of these vaccines, Medicaid does not reimburse for UCVDP/ VFC vaccines for children ages birth through 18. An exception to this is noted below the table.

For Medicaid-eligible recipients ages 19 through 20 who are not age-eligible for the VFC program vaccines, Medicaid will reimburse providers for Medicaid-covered vaccines.

The following is a list of UCVDP/VFC vaccines:

Codes	Vaccines	Diagnosis Codes
90645	Hib Titer- 4 dose HBOC	V03.8 or V05.8
90647	Hib-3 dose PRP-OMP (Pedvax)	V03.8 or V05.8
90648	Hib-4 dose PRT-T (ActHib)	V03.8 or V05.8
90657	Influenza (6 to 35 months of age) **High-Risk Only**	V04.8
90658	Influenza (3 years of age and above) **High-Risk Only**	V04.8
90669	Pneumococcal - PCV7 **(2 through 59 months of age)**	V03.82 or V05.8
90700	DTaP	V06.8
90702	DT	V06.8
90707	MMR	V06.4
90713	IPV	V04.0
90716	Varicella	V05.4
90718	Td	V06.5
90732	Pneumococcal - PPV23 **High-Risk Only**	V03.82 or V05.8
90744	Hepatitis B Vaccine – Pediatric/Adolescent If the first dose of hepatitis B vaccine is administered prior to the 19th birthday, UCVDP vaccine can be used to complete the series prior to the 20th birthday. Medicaid will reimburse for hepatitis B vaccine for **high-risk** individuals 19 years of age and older	V05.8

North Carolina Medicaid providers who are not enrolled in the UCVDP or who have questions concerning the program should call the N.C. Division of Public Health's Immunization Branch at 1-800-344-0569.

Out-of-state providers (within the 40-mile radius of North Carolina) may obtain VFC vaccines by calling their state VFC program. VFC program telephone numbers for border states are listed below:

- **Georgia** 1-404-657-5013
- **South Carolina** 1-800-277-4687
- **Tennessee** 1-615-532-8513
- **Virginia** 1-804-786-6246

HEALTH CHECK BILLING REQUIREMENTS

Instructions for billing a Health Check screening on the CMS-1500 claim form are the same as when billing for other medical services except for these six critical requirements. The six billing **requirements** specific to the Health Check Program are as follows:

Requirement 1: Identify and Record Diagnosis Code(s)

Place diagnosis code(s) in the correct order in block 21. Medical diagnoses should **always** be listed before immunization diagnoses. Immunization diagnoses are required when billing immunization(s) only.

Periodic Health Check Screening – Use V20.2 as the Primary Diagnosis
Medical diagnoses are listed after the primary diagnosis (V20.2). Medical diagnoses should **always** be listed before immunization diagnoses. Immunization diagnoses are required when billing immunization(s) only.

Interperiodic Health Check Screening – Use V70.3 as the Primary Diagnosis
Medical diagnoses are listed after the primary diagnosis (V70.3). Medical diagnoses should **always** be listed before immunization diagnoses. Immunization diagnoses are required when billing immunization(s) only.

Requirement 2: Identify and Record Preventive Medicine Code(s)

The preventive medicine CPT codes with the EP modifier for Health Check screenings should be billed as outlined below. In addition to billing the preventive medicine codes, vision and hearing CPT codes must be listed based on the ages outlined in the Health Check Screening Components indicated on page 1.

- A Health Check screening is the only well child visit reimbursable by Medicaid and must have V20.2 or V70.3 as the primary diagnosis code.

- Vision and hearing CPT codes must be listed in addition to the preventive medicine CPT codes for a periodic Health Check screening. No additional reimbursement is allowed for these codes.

Use the correct Health Check screening preventive medicine codes with the EP modifier in block 24D of the CMS-1500 claim form:

Screenings	Preventive CPT Codes and Modifier	Diagnoses Codes
Periodic Screening	CPT codes 99381-99385; 99391-99395 EP Modifier is required in block 24D Vision CPT code 99172 or 99173; beginning at age 3 EP Modifier is required in block 24D Hearing CPT code 92551 or 92552; beginning at age 4 EP Modifier is required in block 24D	V20.2 Primary Diagnosis
Interperiodic Screening	CPT codes 99381-99385; 99391-99395 EP Modifier is required in block 24D	V70.3 Primary Diagnosis

Health Check Billing Requirements, continued

Requirement 3: Health Check Modifier – EP

The Health Check screening CPT codes for periodic and interperiodic screenings must have the **EP** modifier listed in block 24D of the CMS-1500 claim form. The vision and hearing CPT codes must have the **EP** modifier listed in block 24D of the CMS-1500 claim form. EP is a required modifier for all Health Check claims.

Requirement 4: Record the Referral Code Indicator – R

A referral code indicator is used only when a follow-up visit is necessary for a diagnosis found during a Health Check screening. The indicator "R" should be listed in block 24H of the CMS-1500 claim form when this situation occurs. Refer to pages 17, 18, 28, and 29 for sample claims.

Requirement 5: Next Screening Date

Providers may enter the next screening date (NSD) or have the NSD systematically entered according to the predetermined Medicaid periodicity schedule. Below is an explanation of options for the NSD in block 15 of the CMS-1500 claim form.

Systematically Entered Next Screening Date

Providers have the following choices for block 15 of the CMS-1500 claim form with a Health Check screening. All of these choices will result in an automatically entered NSD.

- **Leave block 15 blank.**
- **Place all zeros in block 15 (00/00/0000).**
- **Place all ones in block 15 (11/11/1111).**

Claims with systematically entered NSDs will be tracked per the Medicaid periodicity schedule.

Provider-Entered Next Screening Date

Providers have the option of entering the NSD in block 15. If this date is within the periodicity schedule, the system will keep this date. In the event the NSD is out of range with the periodicity schedule, the system will override the provider's NSD and the appropriate NSD (based upon the periodicity schedule) will be automatically entered during claims processing.

Requirement 6: Identify and Record Immunization Administration CPT Code(s) and the EP Modifier

Refer to the chart on page 7 for guidelines on when to bill the immunization administration CPT codes and the EP modifier.

When billing one immunization, use the administration CPT code 90471 (one unit) with the EP modifier listed in block 24D.

When additional immunizations are provided, use the administration CPT code 90472 with the EP modifier listed in block 24D.

Refer to pages 18, 19, 20/21, 22/23, 24 through 27, 29, and 32 for sample claims.

Note: If the **EP** modifier is not listed in block 24D, the reimbursement rate for the CPT codes 90471 and 90472 is $0.00.

TIPS FOR BILLING

All Health Check Providers

- Two screenings on different dates of service cannot be billed on the same claim form.

- If the required vision and/or hearing screenings cannot be performed during a periodic visit due to a condition such as blindness or deafness and the claim is denied, the claim may be resubmitted through the adjustment process with supporting medical record documentation attached.

- When billing immunization administration CPT codes, the EP modifier must be entered in block 24D to receive the reimbursement rate of $13.71 for 90471 (health departments receive $20.00) and $13.71 for 90472 (no additional reimbursement for health departments). If the EP modifier is not entered in block 24D, the reimbursement will be $0.00 per unit. The reimbursement for these codes is $3.41 per unit for non-Health Check related services. Local health departments should follow directions on pages 6 and 7 when billing these codes.

- Third party insurance must be pursued and reported in block 29 of the CMS-1500 claim form when preventive services (well child screenings) are covered. If third party insurance does not cover preventive services, clearly document in the medical record and submit a claim to Medicaid.

- When checking claim status using the Automated Voice Response (AVR) system (1-800-723-4337), AVR requires providers to enter the total amount billed. Due to each Health Check claim being divided into two separate claims for tracking purposes, the total amount billed must also be split between the amount billed for the screening and the amount billed for immunizations and any other service billed on the same date of service. Thus, it will be necessary to check claim status for two separate claims.

Private Sector Health Check Providers Only

- A Health Check screening and an office visit with different dates of service cannot be billed on the same claim form.

- A Health Check screening and an office visit cannot be paid initially on the same date of service. One claim will pay and the other will deny. For the denied claim to be reconsidered, it must be submitted as an adjustment with medical justification and a copy of the Remittance and Status Report (RA) denial attached.

- Immunization administration CPT code 90471 with the EP modifier and 90472 with the EP modifier can be billed with a Health Check screening, office visit or if it is the only service provided that day. When billing in conjunction with a screening CPT code or an office visit code, an immunization diagnosis is not required in block 21 of the claim form. When billing the administration code for immunizations (90471 with the EP modifier and 90472 with the EP modifier) as the only service for that day, providers are required to use an immunization diagnosis in block 21 of the claim form. **Always list immunization CPT procedure codes** when billing 90471with the EP modifier and 90472 with the EP modifier. Refer to the chart on page 7 and the sample claim forms beginning on pages 15 through 27.

Tips for Billing, continued

Federally Qualified Health Center (FQHC) and Rural Health Clinic (RHC) Providers Only

- FQHCs and RHCs must bill Health Check services using their Medicaid provider number with the "C" suffix.

- A Health Check screening and a core visit cannot be paid initially on the same date of service. One claim will pay and the other will deny. For the denied claim to be reconsidered, it must be submitted as an adjustment with medical justification and a copy of the RA denial attached.

- Immunization administration CPT code 90471 with the EP modifier and 90472 with the EP modifier can be billed if it is provided in addition to a Health Check screening CPT code or if it is the only service provided that day. When billing in conjunction with a screening code, an immunization diagnosis is not required in block 21 of the claim form. When billing the administration code for immunizations (90471 with the EP modifier and 90472 with the EP modifier) as the only service for that day, an immunization diagnosis code is required to be entered in block 21 of the claim form. The administration code for immunizations cannot be billed in conjunction with a core visit. For reporting purposes, list immunization procedure codes in the appropriate block on the claim form. **Always list immunization procedure codes** when billing 90471 with the EP modifier and 90742 with the EP modifier. Refer to the chart on page 7 and the sample claim forms on pages 28 through 33.

HEALTH CHECK COORDINATORS

Health Check Coordinators (HCCs) are available to assist both **parents** and **providers** in assuring that Medicaid-eligible children have access to Health Check services. The roles of the HCCs include, but are not limited to the following:

- using the Health Check Automated Information and Notification System (AINS) for identifying and following Medicaid-eligible children, birth through 20 years of age, with regard to services received through the health care system
- assisting families to use the health care services in a consistent and responsible manner
- assisting with scheduling appointments or securing transportation
- acting as a local information, referral, and resource person for families
- providing advocacy services in addressing social, educational or health needs of the recipient
- initiating follow-up as requested by providers when families need special assistance or fail to bring children in for health screenings
- promoting Health Check and health prevention with other public and private organizations

Physicians and other PCPs and their office staff are encouraged to establish a close working relationship with HCCs. Ongoing communication significantly enhances recipient participation in Health Check and help make preventive care services more timely and effective.

HCCs are currently located in 78 North Carolina counties and Qualla Boundary.

HCCs are housed in local health departments, community and rural health centers, and other community agencies. A list of counties with HCCs is available on the DMA website at http://www.dhhs.state.nc.us/dma.

HEALTH CHECK CLAIM FORM SAMPLES

There are 17 CMS-1500 claim form samples, including two split claims (pages 20/21 and 22/23) and six examples of HSIS screens on the following pages.

Note: A copy of the back of the CMS-1500 claim form precedes the first sample. The back of the CMS claim form includes important information regarding Medicaid payments. The section on Medicaid Payments (Provider Certification) specifies that the provider of Medicaid services agrees to accept, as payment in full, the amount paid by the Medicaid program for those claims submitted for payment under that program, with the exception of authorized deductible, coinsurance, copayment or similar cost-sharing charges.

BECAUSE THIS FORM IS USED BY VARIOUS GOVERNMENT AND PRIVATE HEALTH PROGRAMS, SEE SEPARATE INSTRUCTIONS ISSUED BY APPLICABLE PROGRAMS.

NOTICE: Any person who knowingly files a statement of claim containing any misrepresentation or any false, incomplete or misleading information may be guilty of a criminal act punishable under law and may be subject to civil penalties.

REFERS TO GOVERNMENT PROGRAMS ONLY

MEDICARE AND CHAMPUS PAYMENTS: A patient's signature requests that payment be made and authorizes release of any information necessary to process the claim and certifies that the information provided in Blocks 1 through 12 is true, accurate and complete. In the case of a Medicare claim, the patient's signature authorizes any entity to release to Medicare medical and nonmedical information, including employment status, and whether the person has employer group health insurance, liability, no-fault, worker's compensation or other insurance which is responsible to pay for the services for which the Medicare claim is made. See 42 CFR 411.24(a). If item 9 is completed, the patient's signature authorizes release of the information to the health plan or agency shown. In Medicare assigned or CHAMPUS participation cases, the physician agrees to accept the charge determination of the Medicare carrier or CHAMPUS fiscal intermediary as the full charge, and the patient is responsible only for the deductible, coinsurance and noncovered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier or CHAMPUS fiscal intermediary if this is less than the charge submitted. CHAMPUS is not a health insurance program but makes payment for health benefits provided through certain affiliations with the Uniformed Services. Information on the patient's sponsor should be provided in those items captioned in "Insured"; i.e., items 1a, 4, 6, 7, 9, and 11.

BLACK LUNG AND FECA CLAIMS

The provider agrees to accept the amount paid by the Government as payment in full. See Black Lung and FECA instructions regarding required procedure and diagnosis coding systems.

SIGNATURE OF PHYSICIAN OR SUPPLIER (MEDICARE, CHAMPUS, FECA AND BLACK LUNG)

I certify that the services shown on this form were medically indicated and necessary for the health of the patient and were personally furnished by me or were furnished incident to my professional service by my employee under my immediate personal supervision, except as otherwise expressly permitted by Medicare or CHAMPUS regulations.

For services to be considered as "incident" to a physician's professional service, 1) they must be rendered under the physician's immediate personal supervision by his/her employee, 2) they must be an integral, although incidental part of a covered physician's service, 3) they must be of kinds commonly furnished in physician's offices, and 4) the services of nonphysicians must be included on the physician's bills.

For CHAMPUS claims, I further certify that I (or any employee) who rendered services am not an active duty member of the Uniformed Services or a civilian employee of the United States Government or a contract employee of the United States Government, either civilian or military (refer to 5 USC 5536). For Black-Lung claims, I further certify that the services performed were for a Black Lung-related disorder.

No Part B Medicare benefits may be paid unless this form is received as required by existing law and regulations (42 CFR 424.32).

NOTICE: Any one who misrepresents or falsifies essential information to receive payment from Federal funds requested by this form may upon conviction be subject to fine and imprisonment under applicable Federal laws.

NOTICE TO PATIENT ABOUT THE COLLECTION AND USE OF MEDICARE, CHAMPUS, FECA, AND BLACK LUNG INFORMATION
(PRIVACY ACT STATEMENT)

We are authorized by CMS, CHAMPUS and OWCP to ask you for information needed in the administration of the Medicare, CHAMPUS, FECA, and Black Lung programs. Authority to collect information is in section 205(a), 1862, 1872 and 1874 of the Social Security Act as amended, 42 CFR 411.24(a) and 424.5(a) (6), and 44 USC 3101;41 CFR 101 et seq and 10 USC 1079 and 1086; 5 USC 8101 et seq; and 30 USC 901 et seq; 38 USC 613; E.O. 9397.

The information we obtain to complete claims under these programs is used to identify you and to determine your eligibility. It is also used to decide if the services and supplies you received are covered by these programs and to insure that proper payment is made.

The information may also be given to other providers of services, carriers, intermediaries, medical review boards, health plans, and other organizations or Federal agencies, for the effective administration of Federal provisions that require other third parties payers to pay primary to Federal program, and as otherwise necessary to administer these programs. For example, it may be necessary to disclose information about the benefits you have used to a hospital or doctor. Additional disclosures are made through routine uses for information contained in systems of records.

FOR MEDICARE CLAIMS: See the notice modifying system No. 09-70-0501, titled, 'Carrier Medicare Claims Record,' published in the Federal Register, Vol. 55 No. 177, page 37549, Wed. Sept. 12, 1990, or as updated and republished.

FOR OWCP CLAIMS: Department of Labor, Privacy Act of 1974, "Republication of Notice of Systems of Records," Federal Register Vol. 55 No. 40, Wed Feb. 28, 1990, See ESA-5, ESA-6, ESA-12, ESA-13, ESA-30, or as updated and republished.

FOR CHAMPUS CLAIMS: PRINCIPLE PURPOSE(S): To evaluate eligibility for medical care provided by civilian sources and to issue payment upon establishment of eligibility and determination that the services/supplies received are authorized by law.

ROUTINE USE(S): Information from claims and related documents may be given to the Dept. of Veterans Affairs, the Dept. of Health and Human Services and/or the Dept. of Transportation consistent with their statutory administrative responsibilities under CHAMPUS/CHAMPVA; to the Dept. of Justice for representation of the Secretary of Defense in civil actions; to the Internal Revenue Service, private collection agencies, and consumer reporting agencies in connection with recoupment claims; and to Congressional Offices in response to inquiries made at the request of the person to whom a record pertains. Appropriate disclosures may be made to other federal, state, local, foreign government agencies, private business entities, and individual providers of care, on matters relating to entitlement, claims adjudication, fraud, program abuse, utilization review, quality assurance, peer review, program integrity, third-party liability, coordination of benefits, and civil and criminal litigation related to the operation of CHAMPUS.

DISCLOSURES: Voluntary; however, failure to provide information will result in delay in payment or may result in denial of claim. With the one exception discussed below, there are no penalties under these programs for refusing to supply information. However, failure to furnish information regarding the medical services rendered or the amount charged would prevent payment of claims under these programs. Failure to furnish any other information, such as name or claim number, would delay payment of the claim. Failure to provide medical information under FECA could be deemed an obstruction.

It is mandatory that you tell us if you know that another party is responsible for paying for your treatment. Section 1128B of the Social Security Act and 31 USC 3801-3812 provide penalties for withholding this information.

You should be aware that P. L. 100-503, the "Computer Matching and Privacy Protection Act of 1988", permits the government to verify information by way of computer matches.

MEDICAID PAYMENTS (PROVIDER CERTIFICATION)

I hereby agree to keep such records as are necessary to disclose fully the extent of services provided to individuals under the State's Title XIX plan and to furnish information regarding any payments claimed for providing such services as the State Agency or Dept. of Health and Humans Services may request.

I further agree to accept, as payment in full, the amount paid by the Medicaid program for those claims submitted for payment under that program, with the exception of authorized deductible, coinsurance, co-payment or similar cost-sharing charge.

SIGNATURE OF PHYSICIAN (OR SUPPLIER): I certify that the services listed above were medically indicated and necessary to the health of this patient and were personally furnished by me or my employee under my personal direction.

NOTICE: This is to certify that the foregoing information is true, accurate and complete. I understand that payment and satisfaction of this claim will be from Federal and State funds, and that any false claims, statements, or documents, or concealment of a material fact, may be prosecuted under applicable Federal or State laws.

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0008. The time required to complete this information collection is estimated to average 10 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, N2-14-26, 7500 Security Boulevard, Baltimore, Maryland 21244-1850.

PLEASE DO NOT STAPLE IN THIS AREA

[redacted]

°Private Provider
°Periodic Screening
°Vision and hearing

PICA

HEALTH INSURANCE CLAIM FORM

PICA

CARRIER

1. MEDICARE (Medicare #) MEDICAID (Medicaid #) CHAMPUS (Sponsor's SSN) CHAMPVA (VA File #) GROUP HEALTH PLAN (SSN or ID) FECA BLK LUNG (SSN) OTHER (ID)			1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1): 111111111X
2. PATIENT'S NAME (Last Name, First Name, Middle Initial): Recipient, Joe	3. PATIENT'S BIRTH DATE MM DD YY: 05 03 1997 SEX: M x F		4. INSURED'S NAME (Last Name, First Name, Middle Initial)
5. PATIENT'S ADDRESS (No., Street): 111 Recipient Street	6. PATIENT RELATIONSHIP TO INSURED: Self Spouse Child Other		7. INSURED'S ADDRESS (No., Street)
CITY: Recipient Town STATE: NC	8. PATIENT STATUS: Single Married Other; Employed Full-Time Student Part-Time Student		CITY STATE
ZIP CODE: 12345 TELEPHONE (Include Area Code): (999)999-9999			ZIP CODE TELEPHONE (INCLUDE AREA CODE): ( )
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)	10. IS PATIENT'S CONDITION RELATED TO:		11. INSURED'S POLICY GROUP OR FECA NUMBER
a. OTHER INSURED'S POLICY OR GROUP NUMBER	a. EMPLOYMENT? (CURRENT OR PREVIOUS) YES NO		a. INSURED'S DATE OF BIRTH MM DD YY SEX M F
b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M F	b. AUTO ACCIDENT? YES NO PLACE (State)		b. EMPLOYER'S NAME OR SCHOOL NAME
c. EMPLOYER'S NAME OR SCHOOL NAME	c. OTHER ACCIDENT? YES NO		c. INSURANCE PLAN NAME OR PROGRAM NAME
d. INSURANCE PLAN NAME OR PROGRAM NAME	10d. RESERVED FOR LOCAL USE		d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO *If yes*, return to and complete item 9 a-d.

PATIENT AND INSURED INFORMATION

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.
SIGNED _____ DATE _____

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.
SIGNED _____

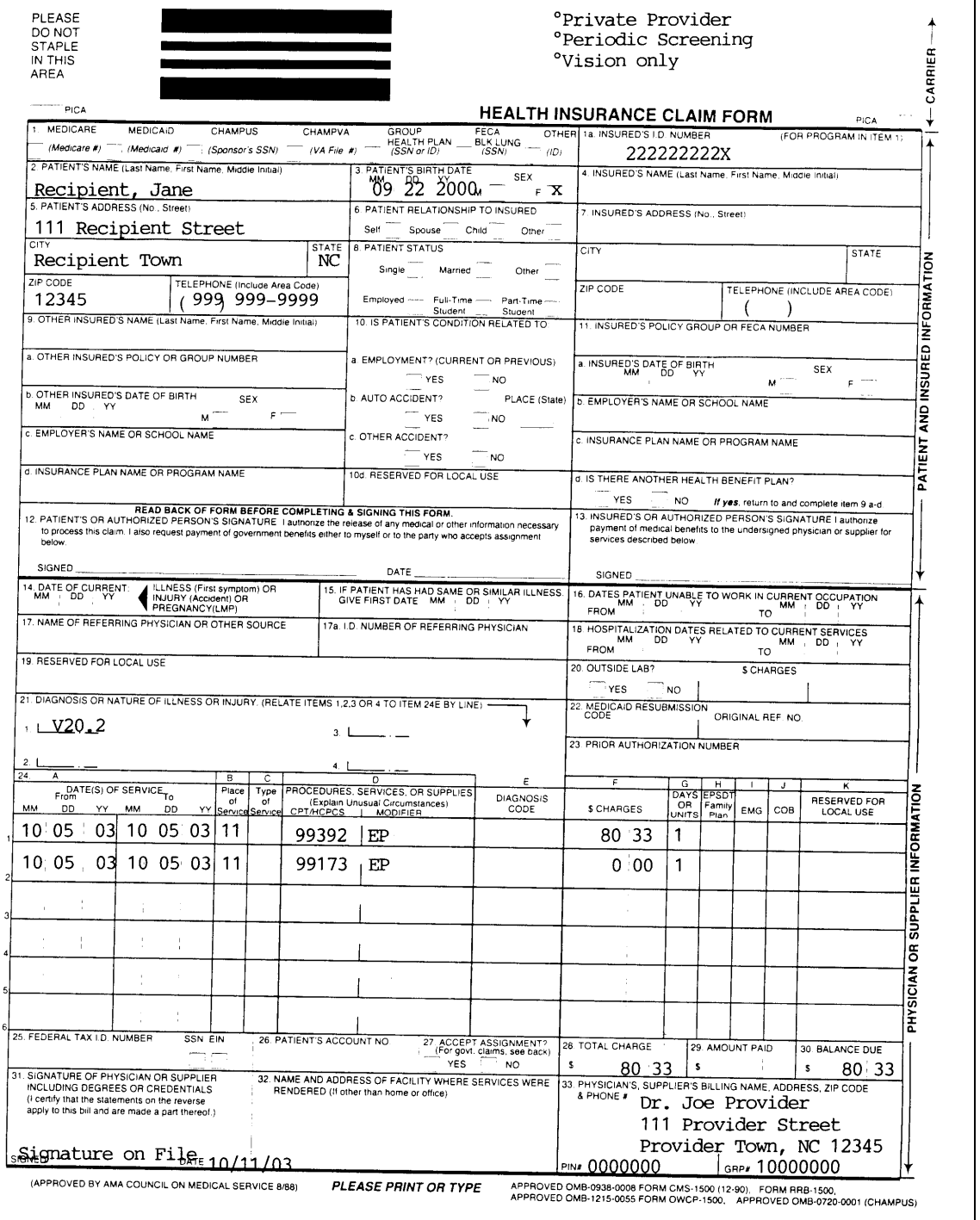
14. DATE OF CURRENT: ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP) MM DD YY	15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE MM DD YY: 11 15 2006	16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY
17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE	17a. I.D. NUMBER OF REFERRING PHYSICIAN	18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY
19. RESERVED FOR LOCAL USE		20. OUTSIDE LAB? YES NO $ CHARGES
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE): 1. V20.2 2. 3. 4.		22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.
		23. PRIOR AUTHORIZATION NUMBER

PHYSICIAN OR SUPPLIER INFORMATION

24. A DATE(S) OF SERVICE From MM DD YY To MM DD YY	B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
1 11 14 03 11 14 03	11		99383 EP		80 33	1				
2 11 14 03 11 14 03	11		99172 EP		0 00	1				
3 11 14 03 11 14 03	11		92552 EP		0 00	1				
4										
5										
6										

25. FEDERAL TAX I.D. NUMBER SSN EIN	26. PATIENT'S ACCOUNT NO.	27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES NO	28. TOTAL CHARGE $ 80 33 / 29. AMOUNT PAID $ / 30. BALANCE DUE $ 8033
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.) SIGNED Signature on File DATE 11/16/03	32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)		33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE # Dr. Jane Provider 111 Provider St. Provider Town, NC 12345 PIN# 0000000 GRP# 1000000

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88) ***PLEASE PRINT OR TYPE*** APPROVED OMB-0938-0008 FORM CMS-1500 (12-90). FORM RRB-1500. APPROVED OMB-1215-0055 FORM OWCP-1500. APPROVED OMB-0720-0001 (CHAMPUS)



PLEASE DO NOT STAPLE IN THIS AREA

[redacted]

°Private Provider
°Periodic Screening
°Vision only

PICA

HEALTH INSURANCE CLAIM FORM

PICA

CARRIER

1. MEDICARE (Medicare #) MEDICAID (Medicaid #) CHAMPUS (Sponsor's SSN) CHAMPVA (VA File #) GROUP HEALTH PLAN (SSN or ID) FECA BLK LUNG (SSN) OTHER (ID)

1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1): 222222222X

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): Recipient, Jane

3. PATIENT'S BIRTH DATE MM DD YY: 09 22 2000 SEX M F X

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street): 111 Recipient Street

6. PATIENT RELATIONSHIP TO INSURED: Self Spouse Child Other

7. INSURED'S ADDRESS (No., Street)

CITY: Recipient Town STATE: NC

8. PATIENT STATUS: Single Married Other; Employed Full-Time Student Part-Time Student

CITY STATE

ZIP CODE: 12345 TELEPHONE (Include Area Code): (999) 999-9999

ZIP CODE TELEPHONE (INCLUDE AREA CODE) ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (CURRENT OR PREVIOUS) YES NO

a. INSURED'S DATE OF BIRTH MM DD YY SEX M F

b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M F

b. AUTO ACCIDENT? YES NO PLACE (State)

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? YES NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO *If yes*, return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED _____ DATE _____

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED _____

14. DATE OF CURRENT: MM DD YY ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE

17a. I.D. NUMBER OF REFERRING PHYSICIAN

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)

1. V20.2
2.
3.
4.

22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
1 10 05 03	10 05 03	11		99392	EP		80 33	1				
2 10 05 03	10 05 03	11		99173	EP		0 00	1				
3												
4												
5												
6												

25. FEDERAL TAX I.D. NUMBER SSN EIN

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES NO

28. TOTAL CHARGE $ 80 33

29. AMOUNT PAID $

30. BALANCE DUE $ 80 33

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

SIGNED Signature on File DATE 10/11/03

32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)

33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #

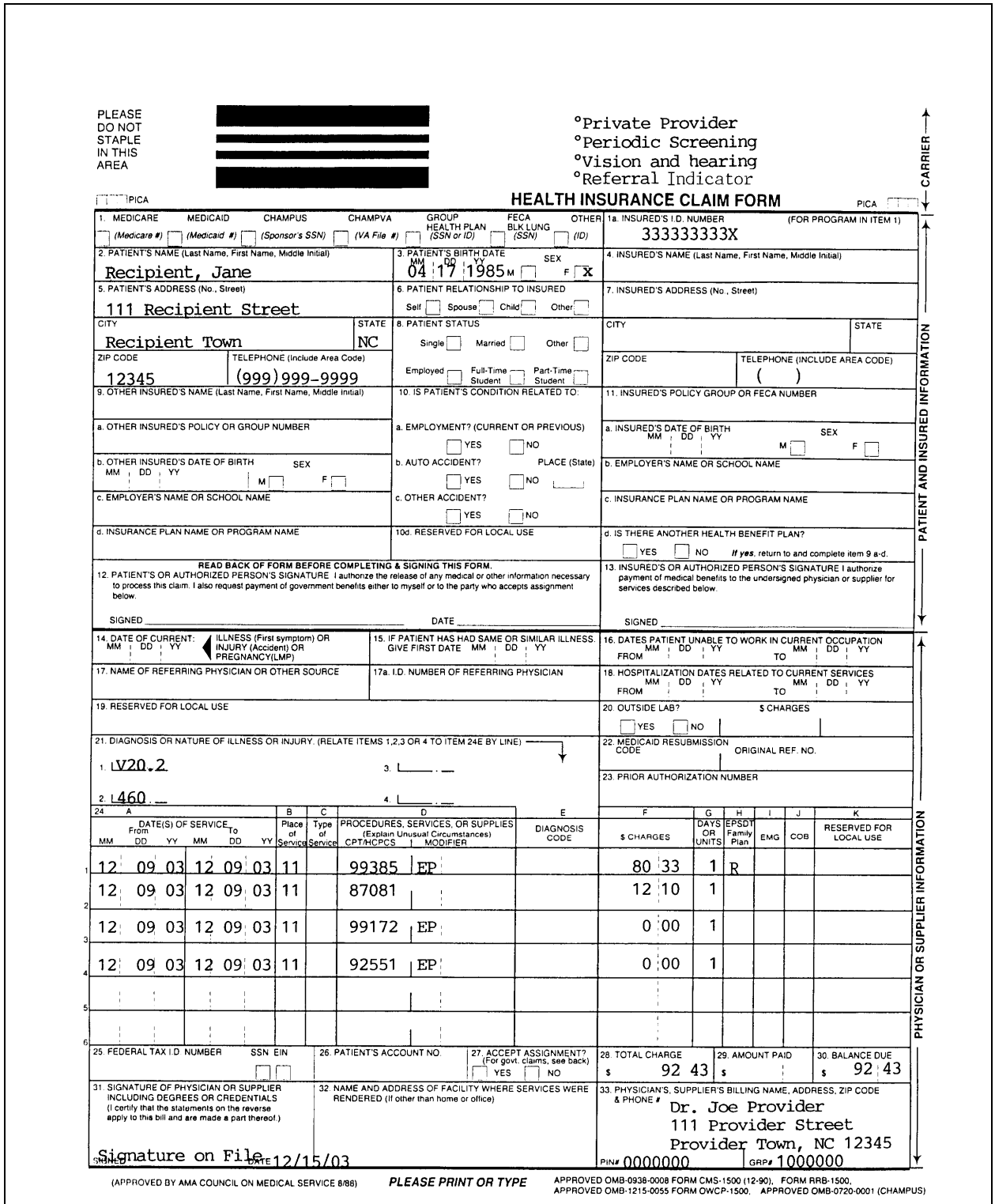
Dr. Joe Provider
111 Provider Street
Provider Town, NC 12345

PIN# 0000000 GRP# 10000000

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88) ***PLEASE PRINT OR TYPE*** APPROVED OMB-0938-0008 FORM CMS-1500 (12-90). FORM RRB-1500, APPROVED OMB-1215-0055 FORM OWCP-1500, APPROVED OMB-0720-0001 (CHAMPUS)



PLEASE DO NOT STAPLE IN THIS AREA

[redacted]

°Private Provider
°Periodic Screening
°Vision and hearing
°Referral Indicator

PICA

HEALTH INSURANCE CLAIM FORM

PICA

CARRIER

1. MEDICARE ☐ (Medicare #) MEDICAID ☐ (Medicaid #) CHAMPUS ☐ (Sponsor's SSN) CHAMPVA ☐ (VA File #) GROUP HEALTH PLAN ☐ (SSN or ID) FECA BLK LUNG ☐ (SSN) OTHER ☐ (ID)

1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1): 333333333X

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): Recipient, Jane

3. PATIENT'S BIRTH DATE MM DD YY: 04 17 1985 SEX M ☐ F ☒

4. INSURED'S NAME (Last Name, First Name, Middle Initial):

5. PATIENT'S ADDRESS (No., Street): 111 Recipient Street

6. PATIENT RELATIONSHIP TO INSURED: Self ☐ Spouse ☐ Child ☐ Other ☐

7. INSURED'S ADDRESS (No., Street):

CITY: Recipient Town STATE: NC

8. PATIENT STATUS: Single ☐ Married ☐ Other ☐ Employed ☐ Full-Time Student ☐ Part-Time Student ☐

CITY: STATE:

ZIP CODE: 12345 TELEPHONE (Include Area Code): (999)999-9999

ZIP CODE: TELEPHONE (INCLUDE AREA CODE): ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial):

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (CURRENT OR PREVIOUS) YES ☐ NO ☐

a. INSURED'S DATE OF BIRTH MM DD YY SEX M ☐ F ☐

b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M ☐ F ☐

b. AUTO ACCIDENT? YES ☐ NO ☐ PLACE (State)

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? YES ☐ NO ☐

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES ☐ NO ☐ *If yes*, return to and complete item 9 a-d.

PATIENT AND INSURED INFORMATION

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED _____ DATE _____

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED _____

14. DATE OF CURRENT: MM DD YY ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE

17a. I.D. NUMBER OF REFERRING PHYSICIAN

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES ☐ NO ☐ $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)

1. V20.2
2. 460
3.
4.

22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24 A DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
1 12 09 03	12 09 03	11		99385	EP		80 33	1	R			
2 12 09 03	12 09 03	11		87081			12 10	1				
3 12 09 03	12 09 03	11		99172	EP		0 00	1				
4 12 09 03	12 09 03	11		92551	EP		0 00	1				
5												
6												

PHYSICIAN OR SUPPLIER INFORMATION

25. FEDERAL TAX I.D. NUMBER SSN EIN

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES ☐ NO ☐

28. TOTAL CHARGE $ 92 43

29. AMOUNT PAID $

30. BALANCE DUE $ 92 43

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

Signature on File DATE 12/15/03

32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)

33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #

Dr. Joe Provider
111 Provider Street
Provider Town, NC 12345

PIN# 0000000 GRP# 1000000

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88) ***PLEASE PRINT OR TYPE***

APPROVED OMB-0938-0008 FORM CMS-1500 (12-90), FORM RRB-1500, APPROVED OMB-1215-0055 FORM OWCP-1500, APPROVED OMB-0720-0001 (CHAMPUS)

PLEASE DO NOT STAPLE IN THIS AREA

[redacted]

°Private Provider
°Periodic Screening
°Referral Indicator
°Immunizations

PICA

HEALTH INSURANCE CLAIM FORM

PICA

CARRIER

1. MEDICARE / MEDICAID / CHAMPUS / CHAMPVA / GROUP HEALTH PLAN / FECA BLK LUNG / OTHER	1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1)
☐ (Medicare #) ☐ (Medicaid #) ☐ (Sponsor's SSN) ☐ (VA File #) ☐ (SSN or ID) ☐ (SSN) ☐ (ID)	111111111X
2. PATIENT'S NAME (Last Name, First Name, Middle Initial): Recipient, Joe	3. PATIENT'S BIRTH DATE MM DD YY: 09 06 2001 SEX M [X] F ☐
5. PATIENT'S ADDRESS (No., Street): 111 Recipient Street	6. PATIENT RELATIONSHIP TO INSURED: Self ☐ Spouse ☐ Child ☐ Other ☐
CITY: Recipient Town — STATE: NC	8. PATIENT STATUS: Single ☐ Married ☐ Other ☐
ZIP CODE: 12345 — TELEPHONE (Include Area Code): (999) 999-9999	Employed ☐ Full-Time Student ☐ Part-Time Student ☐
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)	10. IS PATIENT'S CONDITION RELATED TO:
a. OTHER INSURED'S POLICY OR GROUP NUMBER	a. EMPLOYMENT? (CURRENT OR PREVIOUS) YES ☐ NO ☐
b. OTHER INSURED'S DATE OF BIRTH MM DD YY — SEX M ☐ F ☐	b. AUTO ACCIDENT? YES ☐ NO ☐ PLACE (State)
c. EMPLOYER'S NAME OR SCHOOL NAME	c. OTHER ACCIDENT? YES ☐ NO ☐
d. INSURANCE PLAN NAME OR PROGRAM NAME	10d. RESERVED FOR LOCAL USE

4. INSURED'S NAME (Last Name, First Name, Middle Initial)	
7. INSURED'S ADDRESS (No., Street)	
CITY — STATE	
ZIP CODE — TELEPHONE (INCLUDE AREA CODE) ( )	
11. INSURED'S POLICY GROUP OR FECA NUMBER	
a. INSURED'S DATE OF BIRTH MM DD YY — SEX M ☐ F ☐	
b. EMPLOYER'S NAME OR SCHOOL NAME	
c. INSURANCE PLAN NAME OR PROGRAM NAME	
d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES ☐ NO ☐ *If yes*, return to and complete item 9 a-d.	

PATIENT AND INSURED INFORMATION

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED _____ DATE _____

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED _____

14. DATE OF CURRENT: MM DD YY — ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)	15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY: 00 00 0000	16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY — FROM — TO
17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE	17a. I.D. NUMBER OF REFERRING PHYSICIAN	18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY — FROM — TO MM DD YY
19. RESERVED FOR LOCAL USE		20. OUTSIDE LAB? YES ☐ NO ☐ — $ CHARGES
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE): 1 V20.2 — 2 382.9 — 3 ___ — 4 ___		22. MEDICAID RESUBMISSION CODE — ORIGINAL REF. NO.
		23. PRIOR AUTHORIZATION NUMBER

PHYSICIAN OR SUPPLIER INFORMATION

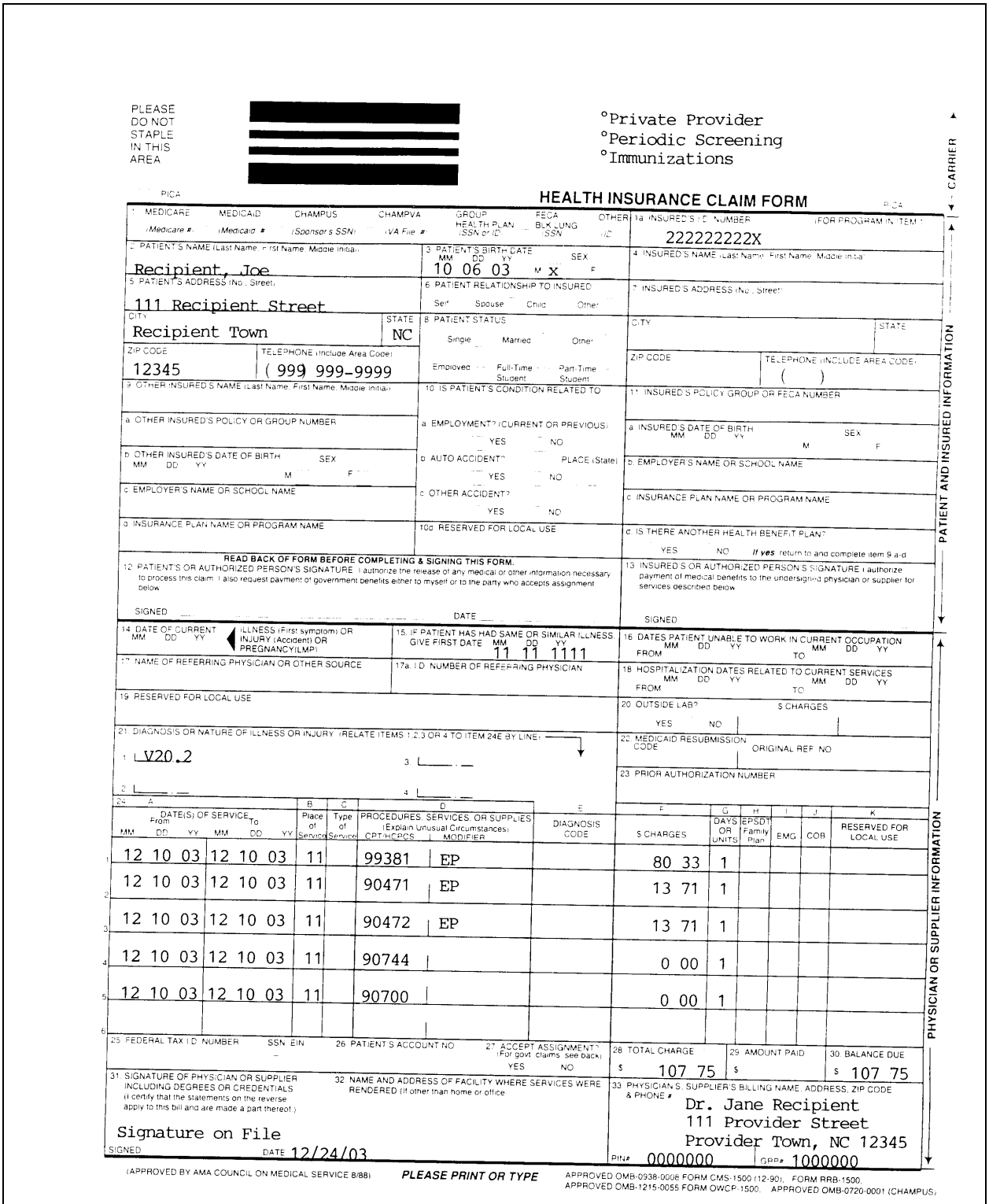
24 A. DATE(S) OF SERVICE From MM DD YY — To MM DD YY	B. Place of Service	C. Type of Service	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS CODE	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. EMG	J. COB	K. RESERVED FOR LOCAL USE
1 11 22 03 — 11 22 03	11		99392	EP		80 33	1	R			
2 11 22 03 — 11 22 03	11		90471	EP		13 71	1				
3 11 22 03 — 11 22 03	11		90472	EP		13 71	1				
4 11 22 03 — 11 22 03	11		90645			0 00	1				
5 11 22 03 — 11 22 03	11		90713			0 00	1				
6 11 22 03 — 11 22 03	11		90669			0 00	1				

25. FEDERAL TAX I.D. NUMBER SSN EIN	26. PATIENT'S ACCOUNT NO.	27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES ☐ NO ☐	28. TOTAL CHARGE $ 107 75	29. AMOUNT PAID $	30. BALANCE DUE $ 107 75

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)	32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)	33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #
Signature on File		Dr. Jane Provider 111 Provider Street Provider Town, NC 12345
SIGNED DATE 12/01/03		PIN# 0000000 GRP# 1000000

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88) ***PLEASE PRINT OR TYPE***

APPROVED OMB-0938-0008 FORM CMS-1500 (12-90), FORM RRB-1500,
APPROVED OMB-1215-0055 FORM OWCP-1500, APPROVED OMB-0720-0001 (CHAMPUS)



PLEASE DO NOT STAPLE IN THIS AREA

[redacted]

°Private Provider
°Periodic Screening
°Immunizations

PICA

HEALTH INSURANCE CLAIM FORM

PICA

1. MEDICARE (Medicare #) MEDICAID (Medicaid #) CHAMPUS (Sponsor's SSN) CHAMPVA (VA File #) GROUP HEALTH PLAN (SSN or ID) FECA BLK LUNG (SSN) OTHER

1a. INSURED'S I.D. NUMBER: 222222222X

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): Recipient, Joe

3. PATIENT'S BIRTH DATE: 10 06 03 SEX: M x F

4. INSURED'S NAME (Last Name, First Name, Middle Initial):

5. PATIENT'S ADDRESS (No., Street): 111 Recipient Street

6. PATIENT RELATIONSHIP TO INSURED: Self Spouse Child Other

7. INSURED'S ADDRESS (No., Street):

CITY: Recipient Town STATE: NC

8. PATIENT STATUS: Single Married Other; Employed Full-Time Student Part-Time Student

CITY: STATE:

ZIP CODE: 12345 TELEPHONE (Include Area Code): (999) 999-9999

ZIP CODE: TELEPHONE (INCLUDE AREA CODE): ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial):

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER:

a. OTHER INSURED'S POLICY OR GROUP NUMBER:

a. EMPLOYMENT? (CURRENT OR PREVIOUS): YES NO

a. INSURED'S DATE OF BIRTH: MM DD YY SEX: M F

b. OTHER INSURED'S DATE OF BIRTH: MM DD YY SEX: M F

b. AUTO ACCIDENT? YES NO PLACE (State)

b. EMPLOYER'S NAME OR SCHOOL NAME:

c. EMPLOYER'S NAME OR SCHOOL NAME:

c. OTHER ACCIDENT? YES NO

c. INSURANCE PLAN NAME OR PROGRAM NAME:

d. INSURANCE PLAN NAME OR PROGRAM NAME:

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO *If yes*, return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE: I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED: DATE:

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE: I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED:

14. DATE OF CURRENT: MM DD YY ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE: MM DD YY 11 11 1111

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION: MM DD YY FROM TO MM DD YY

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE

17a. I.D. NUMBER OF REFERRING PHYSICIAN

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES: MM DD YY FROM TO MM DD YY

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)

1. V20.2 3.

2. 4.

22. MEDICAID RESUBMISSION CODE: ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
1 12 10 03	12 10 03	11		99381	EP		80 33	1				
2 12 10 03	12 10 03	11		90471	EP		13 71	1				
3 12 10 03	12 10 03	11		90472	EP		13 71	1				
4 12 10 03	12 10 03	11		90744			0 00	1				
5 12 10 03	12 10 03	11		90700			0 00	1				
6												

25. FEDERAL TAX I.D. NUMBER SSN EIN

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES NO

28. TOTAL CHARGE: $ 107 75

29. AMOUNT PAID: $

30. BALANCE DUE: $ 107 75

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

Signature on File

SIGNED DATE 12/24/03

32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)

33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #

Dr. Jane Recipient
111 Provider Street
Provider Town, NC 12345

PIN# 0000000 GRP# 1000000

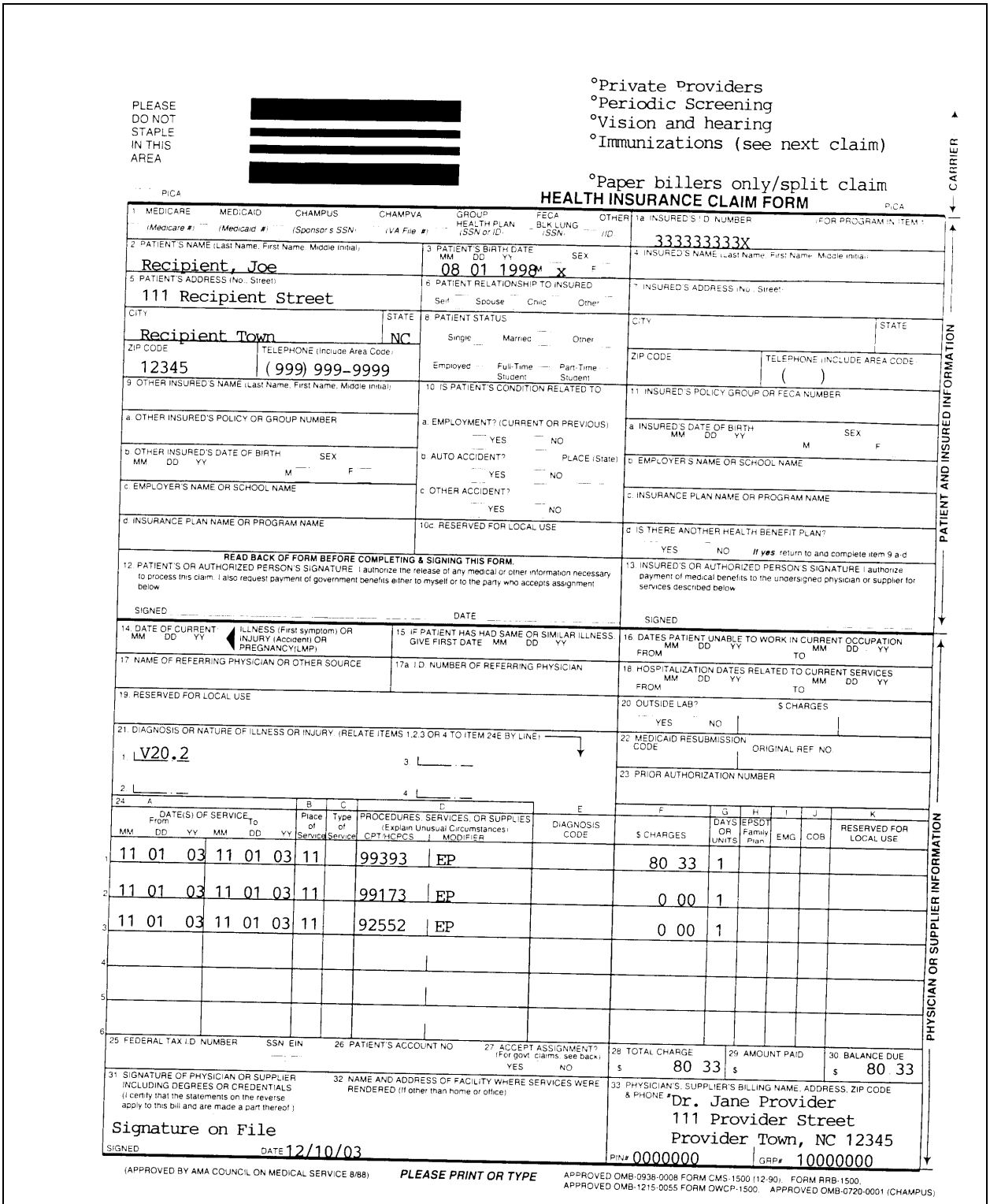
(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88) ***PLEASE PRINT OR TYPE***

APPROVED OMB-0938-0008 FORM CMS-1500 (12-90), FORM RRB-1500,
APPROVED OMB-1215-0055 FORM OWCP-1500, APPROVED OMB-0720-0001 (CHAMPUS)

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

CARRIER



°Private Providers
°Periodic Screening
°Vision and hearing
°Immunizations (see next claim)

°Paper billers only/split claim

PLEASE DO NOT STAPLE IN THIS AREA

[redacted]

PICA

HEALTH INSURANCE CLAIM FORM

PICA

1. MEDICARE (Medicare #) MEDICAID (Medicaid #) CHAMPUS (Sponsor's SSN) CHAMPVA (VA File #) GROUP HEALTH PLAN (SSN or ID) FECA BLK LUNG (SSN) OTHER (ID)

1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1): 333333333X

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): Recipient, Joe

3. PATIENT'S BIRTH DATE MM DD YY: 08 01 1998 SEX: M x F

4. INSURED'S NAME (Last Name, First Name, Middle Initial):

5. PATIENT'S ADDRESS (No., Street): 111 Recipient Street

6. PATIENT RELATIONSHIP TO INSURED: Self Spouse Child Other

7. INSURED'S ADDRESS (No., Street):

CITY: Recipient Town STATE: NC

8. PATIENT STATUS: Single Married Other; Employed Full-Time Student Part-Time Student

CITY: STATE:

ZIP CODE: 12345 TELEPHONE (Include Area Code): (999) 999-9999

ZIP CODE: TELEPHONE (INCLUDE AREA CODE): ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial):

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER:

a. OTHER INSURED'S POLICY OR GROUP NUMBER:

a. EMPLOYMENT? (CURRENT OR PREVIOUS) YES NO

a. INSURED'S DATE OF BIRTH MM DD YY SEX M F

b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M F

b. AUTO ACCIDENT? PLACE (State) YES NO

b. EMPLOYER'S NAME OR SCHOOL NAME:

c. EMPLOYER'S NAME OR SCHOOL NAME:

c. OTHER ACCIDENT? YES NO

c. INSURANCE PLAN NAME OR PROGRAM NAME:

d. INSURANCE PLAN NAME OR PROGRAM NAME:

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO *If yes*, return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE: I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED: DATE:

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE: I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED:

14. DATE OF CURRENT: MM DD YY ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE

17a. I.D. NUMBER OF REFERRING PHYSICIAN

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)

1. V20.2 3. 2. 4.

22. MEDICAID RESUBMISSION CODE: ORIGINAL REF. NO.:

23. PRIOR AUTHORIZATION NUMBER:

24. A DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
1 11 01 03	11 01 03	11		99393	EP		80 33	1				
2 11 01 03	11 01 03	11		99173	EP		0 00	1				
3 11 01 03	11 01 03	11		92552	EP		0 00	1				
4												
5												
6												

25. FEDERAL TAX I.D. NUMBER SSN EIN

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES NO

28. TOTAL CHARGE $ 80 33

29. AMOUNT PAID $

30. BALANCE DUE $ 80 33

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

Signature on File

SIGNED DATE 12/10/03

32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)

33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #

°Dr. Jane Provider
111 Provider Street
Provider Town, NC 12345

PIN# 0000000 GRP# 10000000

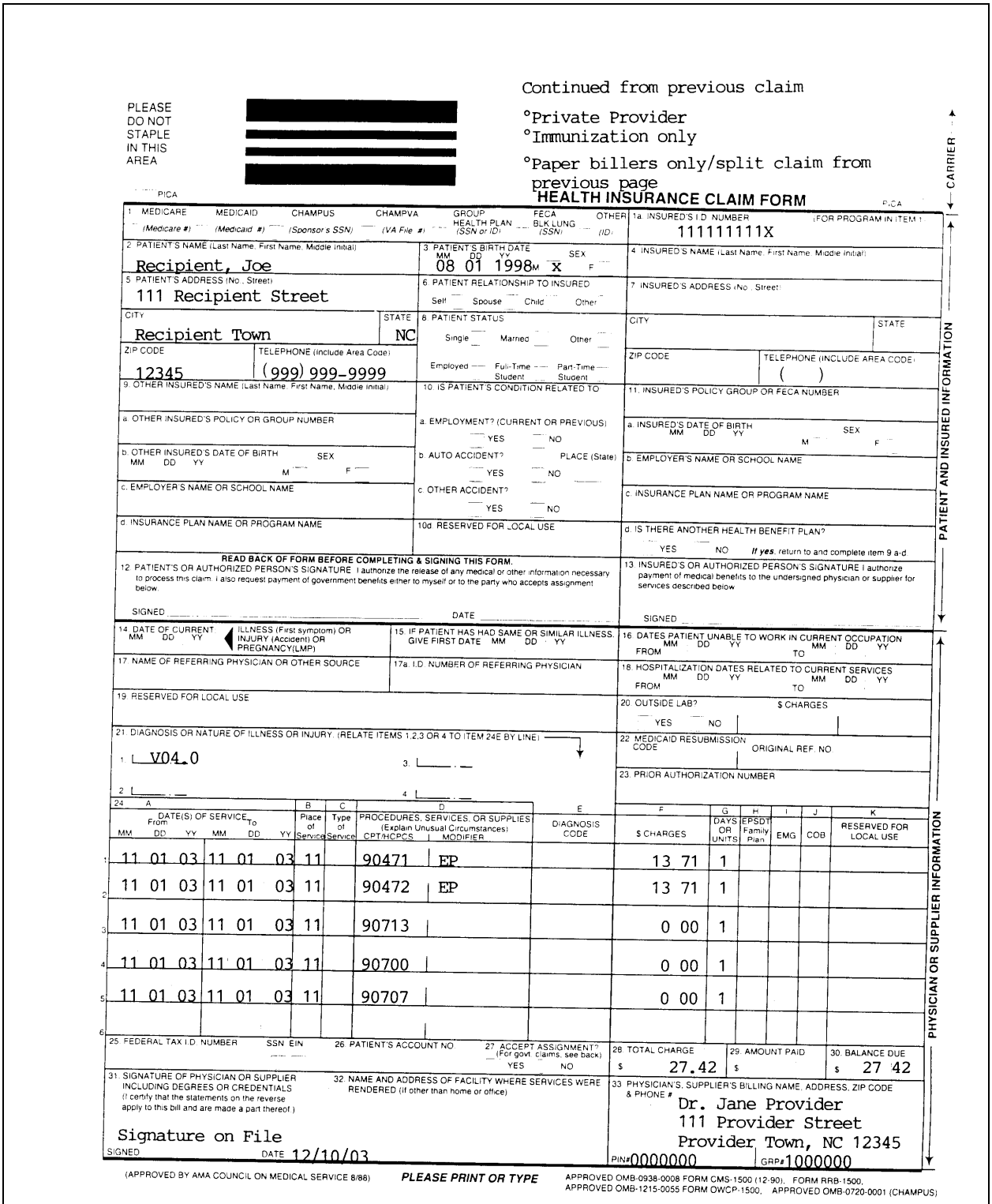
CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88) **PLEASE PRINT OR TYPE**

APPROVED OMB-0938-0008 FORM CMS-1500 (12-90). FORM RRB-1500.
APPROVED OMB-1215-0055 FORM OWCP-1500. APPROVED OMB-0720-0001 (CHAMPUS)



Continued from previous claim

°Private Provider
°Immunization only
°Paper billers only/split claim from previous page

PLEASE DO NOT STAPLE IN THIS AREA

[redacted]

PICA

HEALTH INSURANCE CLAIM FORM

PICA

CARRIER

1. MEDICARE (Medicare #) MEDICAID (Medicaid #) CHAMPUS (Sponsor's SSN) CHAMPVA (VA File #) GROUP HEALTH PLAN (SSN or ID) FECA BLK LUNG (SSN) OTHER (ID)

1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1): 111111111X

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): Recipient, Joe

3. PATIENT'S BIRTH DATE MM DD YY: 08 01 1998 SEX: M X F

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street): 111 Recipient Street

6. PATIENT RELATIONSHIP TO INSURED: Self Spouse Child Other

7. INSURED'S ADDRESS (No., Street)

CITY: Recipient Town STATE: NC

8. PATIENT STATUS: Single Married Other; Employed Full-Time Student Part-Time Student

CITY STATE

ZIP CODE: 12345 TELEPHONE (Include Area Code): (999) 999-9999

ZIP CODE TELEPHONE (INCLUDE AREA CODE): ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (CURRENT OR PREVIOUS) YES NO

a. INSURED'S DATE OF BIRTH MM DD YY SEX M F

b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M F

b. AUTO ACCIDENT? YES NO PLACE (State)

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? YES NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO *If yes*, return to and complete item 9 a-d.

PATIENT AND INSURED INFORMATION

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED _____ DATE _____

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED _____

14. DATE OF CURRENT: MM DD YY ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE

17a. I.D. NUMBER OF REFERRING PHYSICIAN

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)

1. V04.0
2.
3.
4.

22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24 A DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
1 11 01 03	11 01 03	11		90471	EP		13 71	1				
2 11 01 03	11 01 03	11		90472	EP		13 71	1				
3 11 01 03	11 01 03	11		90713			0 00	1				
4 11 01 03	11 01 03	11		90700			0 00	1				
5 11 01 03	11 01 03	11		90707			0 00	1				
6												

PHYSICIAN OR SUPPLIER INFORMATION

25. FEDERAL TAX I.D. NUMBER SSN EIN

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES NO

28. TOTAL CHARGE $ 27.42

29. AMOUNT PAID $

30. BALANCE DUE $ 27 42

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

Signature on File

SIGNED DATE 12/10/03

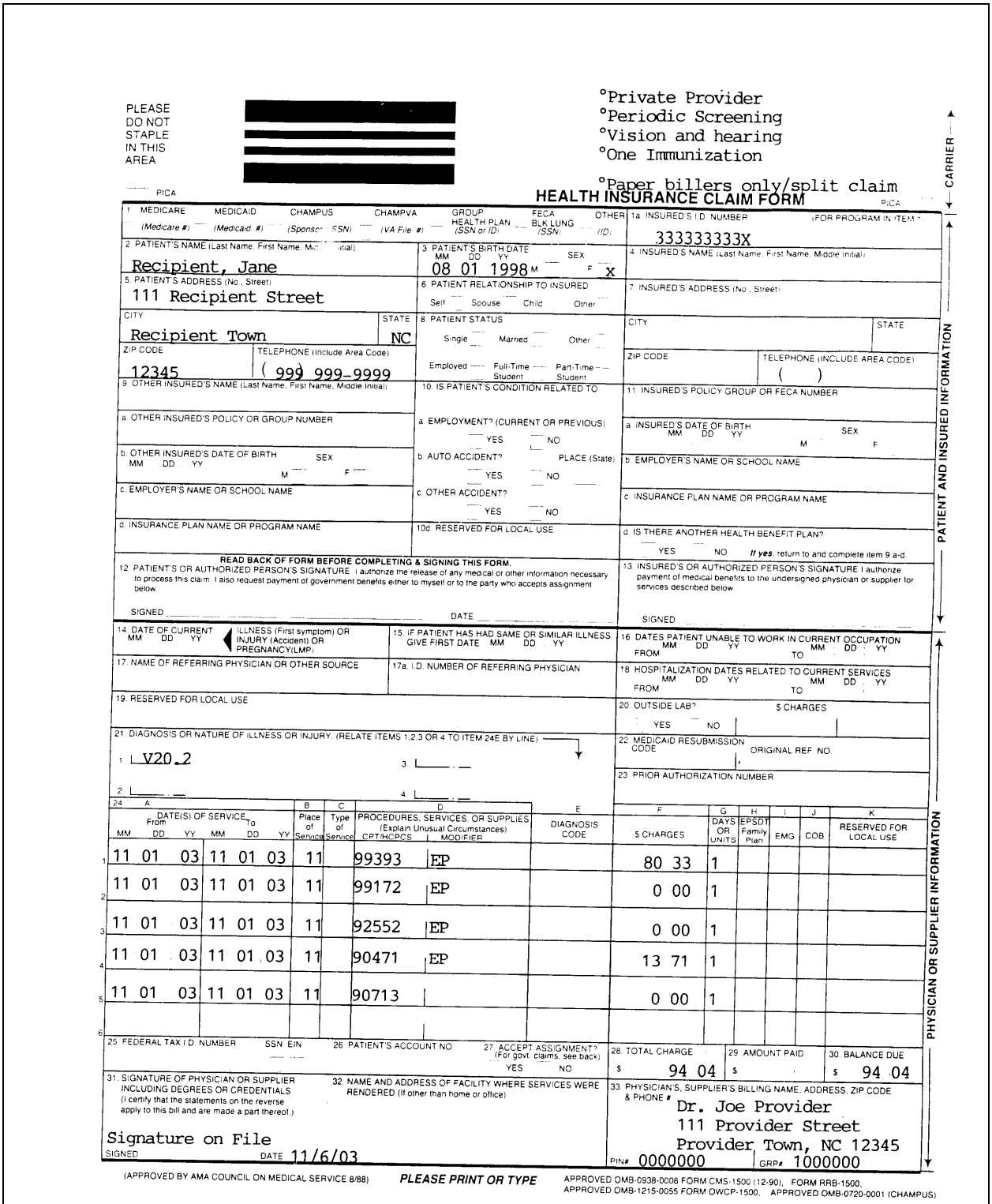
32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)

33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #

Dr. Jane Provider
111 Provider Street
Provider Town, NC 12345

PIN# 0000000 GRP# 1000000

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88) ***PLEASE PRINT OR TYPE*** APPROVED OMB-0938-0008 FORM CMS-1500 (12-90). FORM RRB-1500, APPROVED OMB-1215-0055 FORM OWCP-1500, APPROVED OMB-0720-0001 (CHAMPUS)



PLEASE DO NOT STAPLE IN THIS AREA

[redacted]

°Private Provider
°Periodic Screening
°Vision and hearing
°One Immunization

°Paper billers only/split claim

PICA

HEALTH INSURANCE CLAIM FORM

PICA

CARRIER

1. MEDICARE (Medicare #) MEDICAID (Medicaid #) CHAMPUS (Sponsor's SSN) CHAMPVA (VA File #) GROUP HEALTH PLAN (SSN or ID) FECA BLK LUNG (SSN) OTHER (ID)

1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1): 333333333X

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): Recipient, Jane

3. PATIENT'S BIRTH DATE MM DD YY: 08 01 1998 SEX: M F X

4. INSURED'S NAME (Last Name, First Name, Middle Initial):

5. PATIENT'S ADDRESS (No., Street): 111 Recipient Street

6. PATIENT RELATIONSHIP TO INSURED: Self Spouse Child Other

7. INSURED'S ADDRESS (No., Street):

CITY: Recipient Town STATE: NC

8. PATIENT STATUS: Single Married Other; Employed Full-Time Student Part-Time Student

CITY STATE

ZIP CODE: 12345 TELEPHONE (Include Area Code): (999) 999-9999

ZIP CODE TELEPHONE (INCLUDE AREA CODE): ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (CURRENT OR PREVIOUS) YES NO

a. INSURED'S DATE OF BIRTH MM DD YY SEX M F

b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M F

b. AUTO ACCIDENT? YES NO PLACE (State)

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? YES NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO *If yes*, return to and complete item 9 a-d.

PATIENT AND INSURED INFORMATION

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE. I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED _____ DATE _____

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE. I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED _____

14. DATE OF CURRENT: MM DD YY ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE

17a. I.D. NUMBER OF REFERRING PHYSICIAN

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)

1. V20.2 3. _____

2. _____ 4. _____

22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24 A. DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B. Place of Service	C. Type of Service	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS CODE	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. EMG	J. COB	K. RESERVED FOR LOCAL USE
1 11 01 03	11 01 03	11		99393	EP		80 33	1				
2 11 01 03	11 01 03	11		99172	EP		0 00	1				
3 11 01 03	11 01 03	11		92552	EP		0 00	1				
4 11 01 03	11 01 03	11		90471	EP		13 71	1				
5 11 01 03	11 01 03	11		90713			0 00	1				
6												

PHYSICIAN OR SUPPLIER INFORMATION

25. FEDERAL TAX I.D. NUMBER SSN EIN

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES NO

28. TOTAL CHARGE $ 94 04

29. AMOUNT PAID $

30. BALANCE DUE $ 94 04

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

Signature on File

SIGNED DATE 11/6/03

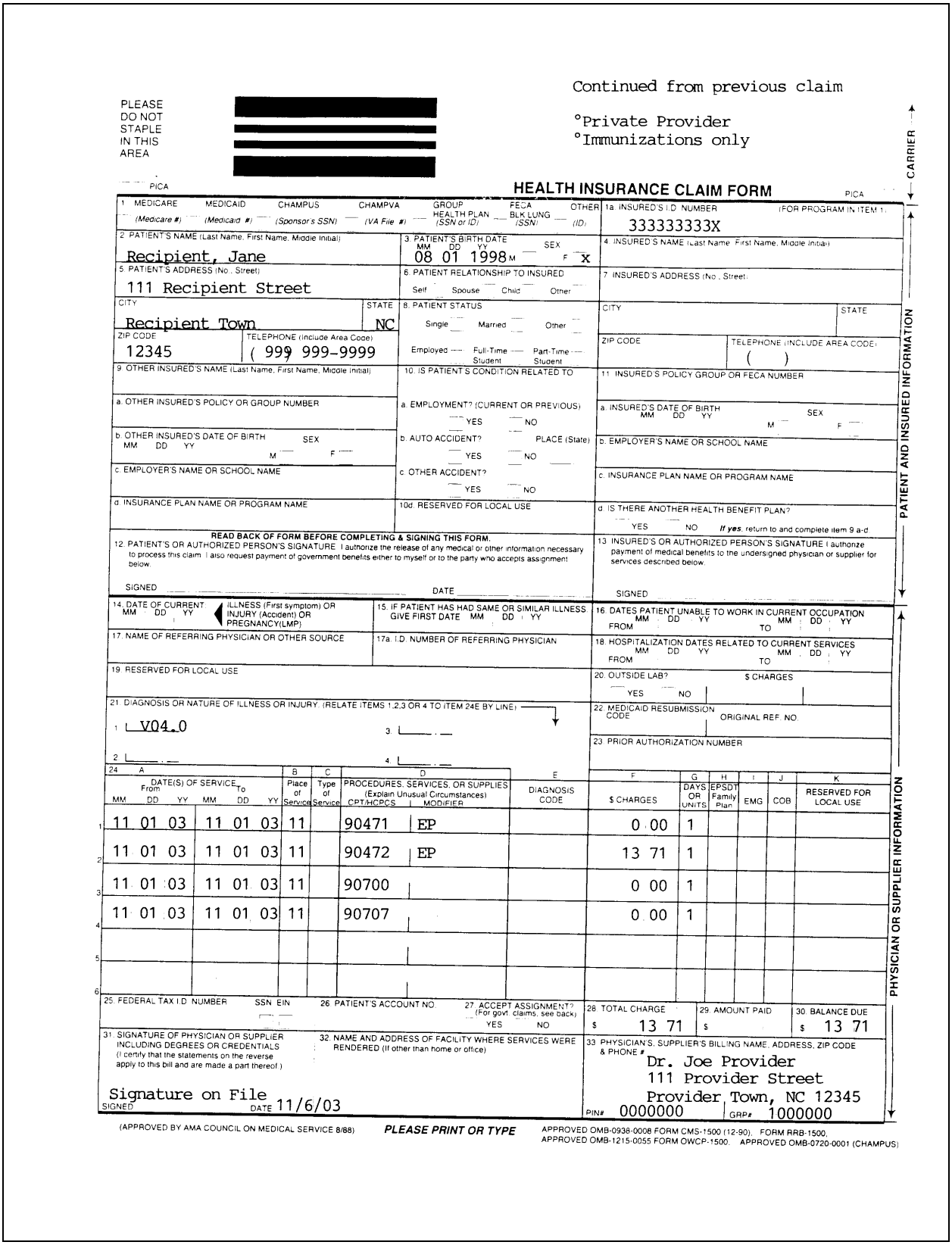
32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)

33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #

Dr. Joe Provider
111 Provider Street
Provider Town, NC 12345

PIN# 0000000 GRP# 1000000

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88) ***PLEASE PRINT OR TYPE*** APPROVED OMB-0938-0008 FORM CMS-1500 (12-90), FORM RRB-1500, APPROVED OMB-1215-0055 FORM OWCP-1500, APPROVED OMB-0720-0001 (CHAMPUS)



Continued from previous claim

°Private Provider
°Immunizations only

PLEASE DO NOT STAPLE IN THIS AREA

[redacted]

PICA

HEALTH INSURANCE CLAIM FORM

PICA

CARRIER

1. MEDICARE (Medicare #) MEDICAID (Medicaid #) CHAMPUS (Sponsor's SSN) CHAMPVA (VA File #) GROUP HEALTH PLAN (SSN or ID) FECA BLK LUNG (SSN) OTHER (ID)

1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1): 333333333X

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): Recipient, Jane

3. PATIENT'S BIRTH DATE MM DD YY: 08 01 1998 SEX M X F

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street): 111 Recipient Street

6. PATIENT RELATIONSHIP TO INSURED: Self Spouse Child Other

7. INSURED'S ADDRESS (No., Street)

CITY: Recipient Town STATE: NC

8. PATIENT STATUS: Single Married Other; Employed Full-Time Student Part-Time Student

CITY STATE

ZIP CODE: 12345 TELEPHONE (Include Area Code): (999) 999-9999

ZIP CODE TELEPHONE (INCLUDE AREA CODE) ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (CURRENT OR PREVIOUS) YES NO

a. INSURED'S DATE OF BIRTH MM DD YY SEX M F

b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M F

b. AUTO ACCIDENT? YES NO PLACE (State)

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? YES NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO *If yes*, return to and complete item 9 a-d.

PATIENT AND INSURED INFORMATION

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED DATE

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED

14. DATE OF CURRENT: MM DD YY ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE

17a. I.D. NUMBER OF REFERRING PHYSICIAN

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)

1. V04.0
2.
3.
4.

22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24 A DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
1 11 01 03	11 01 03	11		90471	EP		0 00	1				
2 11 01 03	11 01 03	11		90472	EP		13 71	1				
3 11 01 03	11 01 03	11		90700			0 00	1				
4 11 01 03	11 01 03	11		90707			0 00	1				
5												
6												

PHYSICIAN OR SUPPLIER INFORMATION

25. FEDERAL TAX I.D. NUMBER SSN EIN

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES NO

28. TOTAL CHARGE $ 13 71

29. AMOUNT PAID $

30. BALANCE DUE $ 13 71

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

Signature on File
SIGNED DATE 11/6/03

32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)

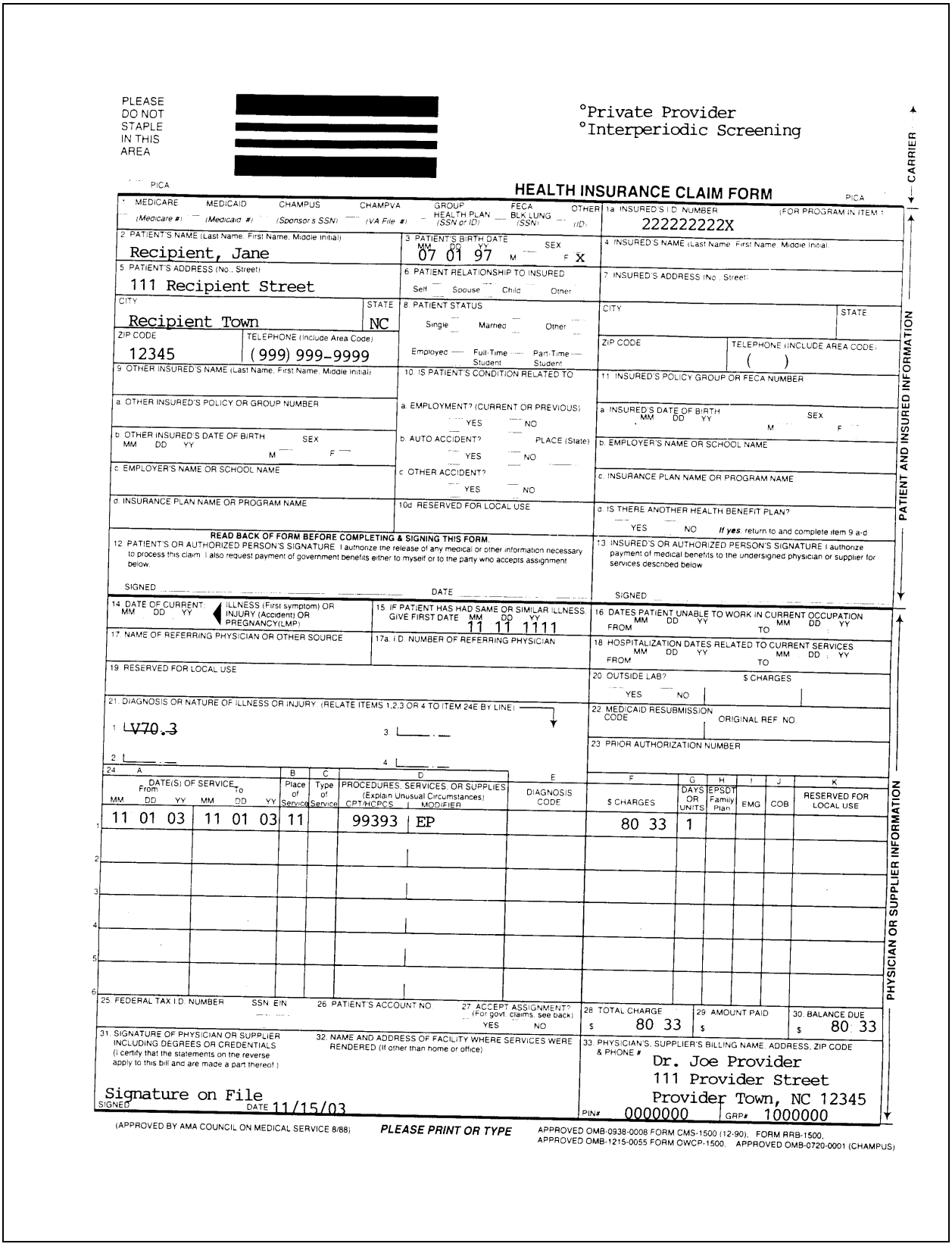
33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #

Dr. Joe Provider
111 Provider Street
Provider Town, NC 12345

PIN# 0000000 GRP# 1000000

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88) **PLEASE PRINT OR TYPE**

APPROVED OMB-0938-0008 FORM CMS-1500 (12-90). FORM RRB-1500, APPROVED OMB-1215-0055 FORM OWCP-1500. APPROVED OMB-0720-0001 (CHAMPUS)



PLEASE DO NOT STAPLE IN THIS AREA

[redacted]

°Private Provider
°Interperiodic Screening

PICA

HEALTH INSURANCE CLAIM FORM

PICA

CARRIER

PATIENT AND INSURED INFORMATION

1. MEDICARE (Medicare #) MEDICAID (Medicaid #) CHAMPUS (Sponsor's SSN) CHAMPVA (VA File #) GROUP HEALTH PLAN (SSN or ID) FECA BLK LUNG (SSN) OTHER (ID)

1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1): 222222222X

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): Recipient, Jane

3. PATIENT'S BIRTH DATE MM DD YY: 07 01 97 SEX: M F X

4. INSURED'S NAME (Last Name, First Name, Middle Initial):

5. PATIENT'S ADDRESS (No., Street): 111 Recipient Street

6. PATIENT RELATIONSHIP TO INSURED: Self Spouse Child Other

7. INSURED'S ADDRESS (No., Street):

CITY: Recipient Town STATE: NC

8. PATIENT STATUS: Single Married Other; Employed Full-Time Student Part-Time Student

CITY STATE

ZIP CODE: 12345 TELEPHONE (Include Area Code): (999) 999-9999

ZIP CODE TELEPHONE (INCLUDE AREA CODE): ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (CURRENT OR PREVIOUS) YES NO

a. INSURED'S DATE OF BIRTH MM DD YY SEX M F

b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M F

b. AUTO ACCIDENT? YES NO PLACE (State)

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? YES NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO *If yes*, return to and complete item 9 a-d

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED DATE

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED

14. DATE OF CURRENT: MM DD YY ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE MM DD YY: 11 11 1111

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE

17a. I.D. NUMBER OF REFERRING PHYSICIAN

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)

1. V70.3
2.
3.
4.

22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

PHYSICIAN OR SUPPLIER INFORMATION

24. A DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
1 11 01 03	11 01 03	11		99393	EP		80 33	1				
2												
3												
4												
5												
6												

25. FEDERAL TAX I.D. NUMBER SSN EIN

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES NO

28. TOTAL CHARGE $ 80 33

29. AMOUNT PAID $

30. BALANCE DUE $ 80 33

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

Signature on File
SIGNED DATE 11/15/03

32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)

33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #

Dr. Joe Provider
111 Provider Street
Provider Town, NC 12345

PIN# 0000000 GRP# 1000000

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88) **PLEASE PRINT OR TYPE**

APPROVED OMB-0938-0008 FORM CMS-1500 (12-90), FORM RRB-1500,
APPROVED OMB-1215-0055 FORM OWCP-1500, APPROVED OMB-0720-0001 (CHAMPUS)

PLEASE DO NOT STAPLE IN THIS AREA

[redacted]

°Private Provider
°Interperiodic Screening
°Immunizations

PICA

HEALTH INSURANCE CLAIM FORM

PICA

MEDICARE (Medicare #) | MEDICAID (Medicaid #) | CHAMPUS (Sponsor's SSN) | CHAMPVA (VA File #) | GROUP HEALTH PLAN (SSN or ID) | FECA BLK LUNG (SSN) | OTHER (ID)

1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1): 333333333X

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): Recipient, Jane

3. PATIENT'S BIRTH DATE (MM DD YY): 02 07 1999 | SEX: M | F X

4. INSURED'S NAME (Last Name, First Name, Middle Initial):

5. PATIENT'S ADDRESS (No., Street): 111 Recipient Street

6. PATIENT RELATIONSHIP TO INSURED: Self | Spouse | Child | Other

7. INSURED'S ADDRESS (No., Street):

CITY: Recipient Town | STATE: NC

8. PATIENT STATUS: Single | Married | Other; Employed | Full-Time Student | Part-Time Student

CITY: | STATE:

ZIP CODE: 12345 | TELEPHONE (Include Area Code): (999 999-9999

ZIP CODE: | TELEPHONE (INCLUDE AREA CODE): ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial):

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER:

a. OTHER INSURED'S POLICY OR GROUP NUMBER:

a. EMPLOYMENT? (CURRENT OR PREVIOUS): YES | NO

a. INSURED'S DATE OF BIRTH (MM DD YY): SEX: M | F

b. OTHER INSURED'S DATE OF BIRTH (MM DD YY): SEX: M | F

b. AUTO ACCIDENT? PLACE (State): YES | NO

b. EMPLOYER'S NAME OR SCHOOL NAME:

c. EMPLOYER'S NAME OR SCHOOL NAME:

c. OTHER ACCIDENT? YES | NO

c. INSURANCE PLAN NAME OR PROGRAM NAME:

d. INSURANCE PLAN NAME OR PROGRAM NAME:

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES | NO *If yes*, return to and complete item 9 a-d

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED: DATE:

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED:

14. DATE OF CURRENT ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP) (MM DD YY):

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE (MM DD YY): 00 00 0000

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION (MM DD YY) FROM TO

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE:

17a. I.D. NUMBER OF REFERRING PHYSICIAN:

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES (MM DD YY) FROM TO

19. RESERVED FOR LOCAL USE:

20. OUTSIDE LAB? YES | NO $ CHARGES:

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)

1. V70.3
2.
3.
4.

22. MEDICAID RESUBMISSION CODE: ORIGINAL REF. NO.:

23. PRIOR AUTHORIZATION NUMBER:

24 A DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
1 12 05 03	12 05 03	11		99382	EP		80 33	1				
2 12 05 03	12 05 03	11		90471	EP		13 71	1				
3 12 05 03	12 05 03	11		90472	EP		13 71	1				
4 12 05 03	12 05 03	11		90700			0 00	1				
5 12 05 03	12 05 03	11		90713			0 00	1				
6 12 05 03	12 05 03	11		90707			0 00	1				

25. FEDERAL TAX I.D. NUMBER: SSN EIN

26. PATIENT'S ACCOUNT NO.:

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES | NO

28. TOTAL CHARGE: $ 107 75

29. AMOUNT PAID: $

30. BALANCE DUE: $ 107 75

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

Signature on File

SIGNED: DATE: 12/07/03

32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)

33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #

Dr. Joe Provider
111 Provider Street
Provider Town, NC 12345

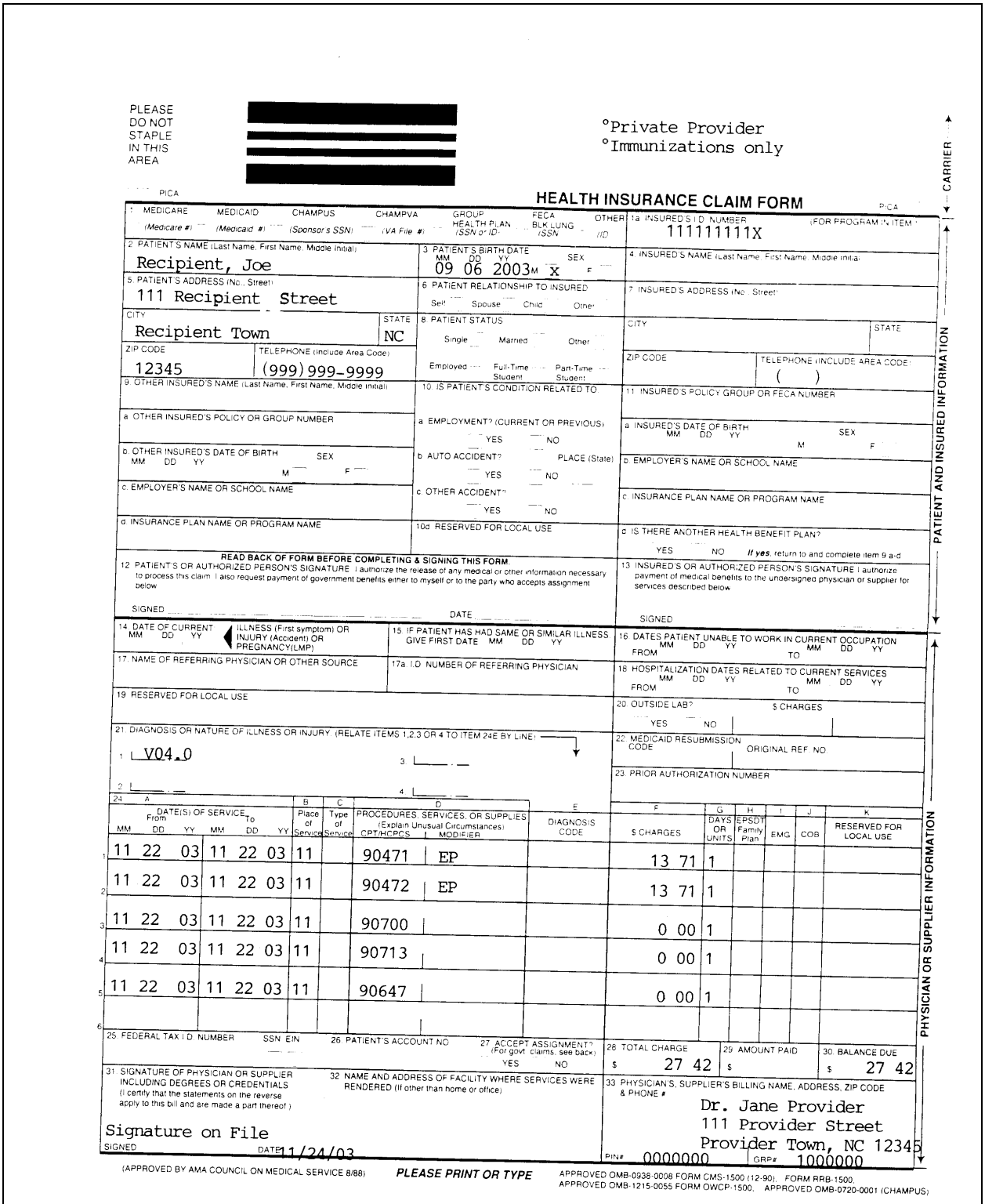
PIN# 0000000 GRP# 10000000

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

CARRIER

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88) ***PLEASE PRINT OR TYPE*** APPROVED OMB-0938-0008 FORM CMS-1500 (12-90), FORM RRB-1500, APPROVED OMB-1215-0055 FORM OWCP-1500, APPROVED OMB-0720-0001 (CHAMPUS)



PLEASE DO NOT STAPLE IN THIS AREA

[redacted]

°Private Provider
°Immunizations only

PICA

HEALTH INSURANCE CLAIM FORM

PICA

1. MEDICARE (Medicare #) MEDICAID (Medicaid #) CHAMPUS (Sponsor's SSN) CHAMPVA (VA File #) GROUP HEALTH PLAN (SSN or ID) FECA BLK LUNG (SSN) OTHER (ID)

1a. INSURED'S I.D. NUMBER: 111111111X (FOR PROGRAM IN ITEM 1)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): Recipient, Joe

3. PATIENT'S BIRTH DATE MM DD YY: 09 06 2003 SEX: M X F

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street): 111 Recipient Street

6. PATIENT RELATIONSHIP TO INSURED: Self Spouse Child Other

7. INSURED'S ADDRESS (No., Street)

CITY: Recipient Town STATE: NC

8. PATIENT STATUS: Single Married Other; Employed Full-Time Student Part-Time Student

CITY STATE

ZIP CODE: 12345 TELEPHONE (Include Area Code): (999) 999-9999

ZIP CODE TELEPHONE (INCLUDE AREA CODE): ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (CURRENT OR PREVIOUS) YES NO

a. INSURED'S DATE OF BIRTH MM DD YY SEX M F

b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M F

b. AUTO ACCIDENT? PLACE (State) YES NO

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? YES NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO *If yes*, return to and complete item 9 a-d

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE. I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED DATE

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE. I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED

14. DATE OF CURRENT ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP) MM DD YY

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE

17a. I.D. NUMBER OF REFERRING PHYSICIAN

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)

1. V04.0 3. 2. 4.

22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
1 11 22 03	11 22 03	11		90471	EP		13 71	1				
2 11 22 03	11 22 03	11		90472	EP		13 71	1				
3 11 22 03	11 22 03	11		90700			0 00	1				
4 11 22 03	11 22 03	11		90713			0 00	1				
5 11 22 03	11 22 03	11		90647			0 00	1				
6												

25. FEDERAL TAX I.D. NUMBER SSN EIN

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES NO

28. TOTAL CHARGE $ 27 42

29. AMOUNT PAID $

30. BALANCE DUE $ 27 42

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

Signature on File

SIGNED DATE 11/24/03

32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)

33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #

Dr. Jane Provider
111 Provider Street
Provider Town, NC 12345

PIN# 0000000 GRP# 1000000

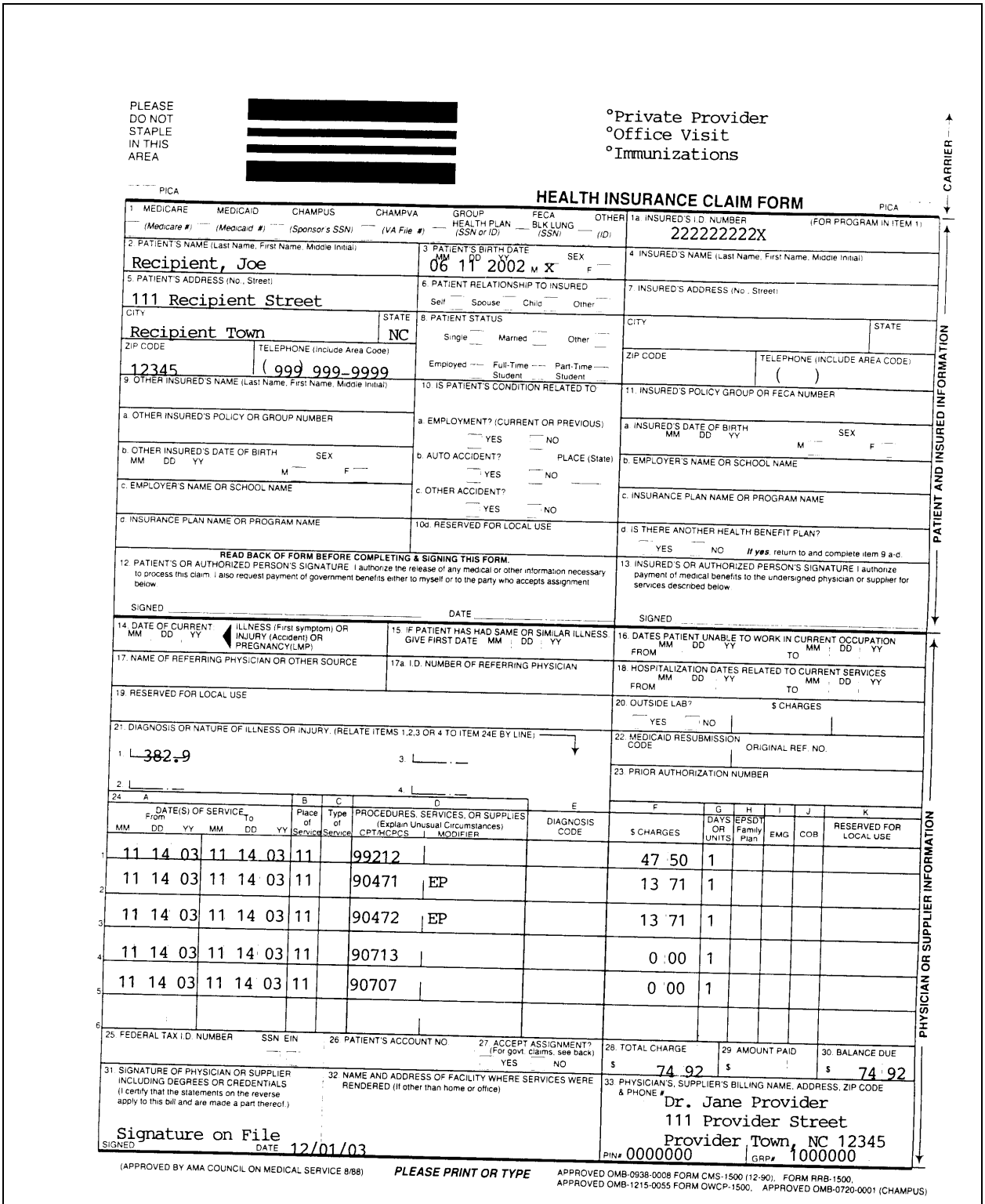
CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88) **PLEASE PRINT OR TYPE**

APPROVED OMB-0938-0008 FORM CMS-1500 (12-90). FORM RRB-1500. APPROVED OMB-1215-0055 FORM OWCP-1500. APPROVED OMB-0720-0001 (CHAMPUS)



PLEASE DO NOT STAPLE IN THIS AREA

[redacted]

°Private Provider
°Office Visit
°Immunizations

PICA

HEALTH INSURANCE CLAIM FORM

PICA — CARRIER

1. MEDICARE (Medicare #) — MEDICAID (Medicaid #) — CHAMPUS (Sponsor's SSN) — CHAMPVA (VA File #) — GROUP HEALTH PLAN (SSN or ID) — FECA BLK LUNG (SSN) — OTHER (ID)

1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1): 222222222X

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): Recipient, Joe

3. PATIENT'S BIRTH DATE MM DD YY: 06 11 2002 — SEX: M X F

4. INSURED'S NAME (Last Name, First Name, Middle Initial):

5. PATIENT'S ADDRESS (No., Street): 111 Recipient Street

6. PATIENT RELATIONSHIP TO INSURED: Self — Spouse — Child — Other

7. INSURED'S ADDRESS (No., Street):

CITY: Recipient Town — STATE: NC

8. PATIENT STATUS: Single — Married — Other — Employed — Full-Time Student — Part-Time Student

CITY — STATE

ZIP CODE: 12345 — TELEPHONE (Include Area Code): (999) 999-9999

ZIP CODE — TELEPHONE (INCLUDE AREA CODE): ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (CURRENT OR PREVIOUS) — YES — NO

a. INSURED'S DATE OF BIRTH MM DD YY — SEX: M — F

b. OTHER INSURED'S DATE OF BIRTH MM DD YY — SEX: M — F

b. AUTO ACCIDENT? — YES — NO — PLACE (State)

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? — YES — NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? — YES — NO — *If yes*, return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED _____ DATE _____

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED

PATIENT AND INSURED INFORMATION

14. DATE OF CURRENT MM DD YY — ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY — FROM — TO

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE

17a. I.D. NUMBER OF REFERRING PHYSICIAN

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY — FROM — TO

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? — YES — NO — $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)

1. ~~382.9~~
2.
3.
4.

22. MEDICAID RESUBMISSION CODE — ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24 A DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
1 11 14 03	11 14 03	11		99212			47 50	1				
2 11 14 03	11 14 03	11		90471	EP		13 71	1				
3 11 14 03	11 14 03	11		90472	EP		13 71	1				
4 11 14 03	11 14 03	11		90713			0 00	1				
5 11 14 03	11 14 03	11		90707			0 00	1				
6												

PHYSICIAN OR SUPPLIER INFORMATION

25. FEDERAL TAX I.D. NUMBER SSN EIN

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) — YES — NO

28. TOTAL CHARGE $ 74 92

29. AMOUNT PAID $

30. BALANCE DUE $ 74 92

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

Signature on File

SIGNED DATE 12/01/03

32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)

33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #

Dr. Jane Provider
111 Provider Street
Provider Town, NC 12345

PIN# 0000000 GRP# 1000000

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88) **PLEASE PRINT OR TYPE**

APPROVED OMB-0938-0008 FORM CMS-1500 (12-90), FORM RRB-1500, APPROVED OMB-1215-0055 FORM OWCP-1500, APPROVED OMB-0720-0001 (CHAMPUS)

PLEASE DO NOT STAPLE IN THIS AREA

[redacted]

°FQHC/RHC
°Periodic Screening
°Vision and hearing
°Referral Indicator

PICA

HEALTH INSURANCE CLAIM FORM

PICA

CARRIER

1. MEDICARE (Medicare #) | MEDICAID (Medicaid #) | CHAMPUS (Sponsor's SSN) | CHAMPVA (VA File #) | GROUP HEALTH PLAN (SSN or ID) | FECA BLK LUNG (SSN) | OTHER (ID)

1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1): 333333333X

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): Recipient, Jane

3. PATIENT'S BIRTH DATE MM DD YY: 07 01 1998 SEX M [ ] F [X]

4. INSURED'S NAME (Last Name, First Name, Middle Initial):

5. PATIENT'S ADDRESS (No., Street): 111 Recipient Street

6. PATIENT RELATIONSHIP TO INSURED: Self [ ] Spouse [ ] Child [ ] Other [ ]

7. INSURED'S ADDRESS (No., Street):

CITY: Recipient Town STATE: NC

8. PATIENT STATUS: Single [ ] Married [ ] Other [ ]

CITY: STATE:

ZIP CODE: 12345 TELEPHONE (Include Area Code): (999) 999-9999

Employed [ ] Full-Time Student [ ] Part-Time Student [ ]

ZIP CODE: TELEPHONE (INCLUDE AREA CODE): ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial):

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER:

a. OTHER INSURED'S POLICY OR GROUP NUMBER:

a. EMPLOYMENT? (CURRENT OR PREVIOUS) YES [ ] NO [ ]

a. INSURED'S DATE OF BIRTH MM DD YY SEX M [ ] F [ ]

b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M [ ] F [ ]

b. AUTO ACCIDENT? YES [ ] NO [ ] PLACE (State)

b. EMPLOYER'S NAME OR SCHOOL NAME:

c. EMPLOYER'S NAME OR SCHOOL NAME:

c. OTHER ACCIDENT? YES [ ] NO [ ]

c. INSURANCE PLAN NAME OR PROGRAM NAME:

d. INSURANCE PLAN NAME OR PROGRAM NAME:

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES [ ] NO [ ] *If yes*, return to and complete item 9 a-d.

PATIENT AND INSURED INFORMATION

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED _____ DATE _____

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED _____

14. DATE OF CURRENT: MM DD YY ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE

17a. I.D. NUMBER OF REFERRING PHYSICIAN

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES [ ] NO [ ] $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)

1. L V20.2
2. L 382.9
3. L 034.0
4. L 460

22. MEDICAID RESUBMISSION CODE: ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER:

24. A DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
1 10 11 03	10 11 03	11		99383	EP		80 33	1	R			
2 10 11 03	10 11 03	11		99172	EP		0 00	1				
3 10 11 03	10 11 03	11		92552	EP		0 00	1				
4												
5												
6												

PHYSICIAN OR SUPPLIER INFORMATION

25. FEDERAL TAX I.D. NUMBER SSN EIN [ ] [ ]

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES [ ] NO [ ]

28. TOTAL CHARGE $ 80 33

29. AMOUNT PAID $

30. BALANCE DUE $ 80 33

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

Signature on File

SIGNED DATE 11/12/03

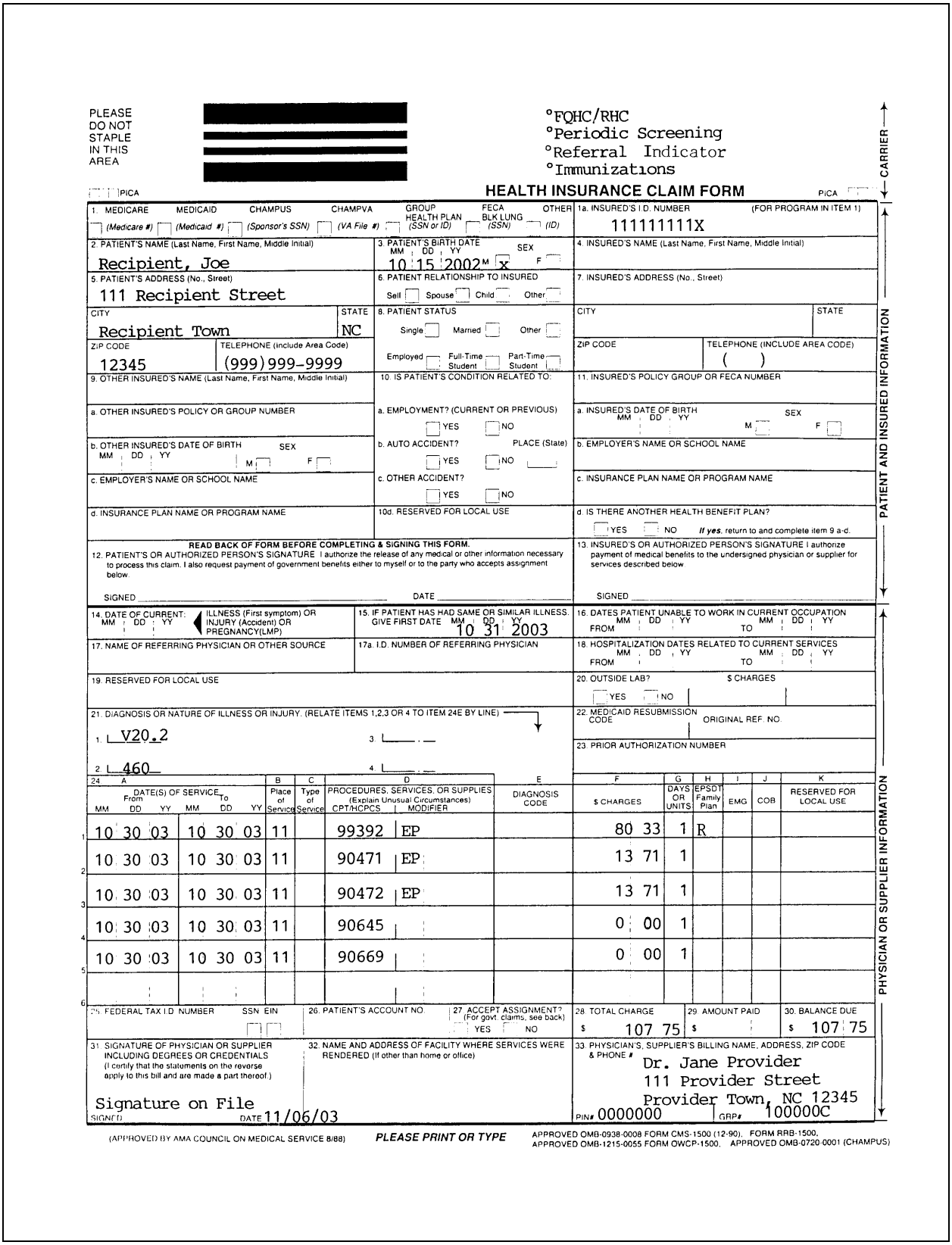
32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)

33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #

Dr. Joe Provider
111 Provider Street
Provider Town, NC 12345

PIN# 0000000 GRP# 100000C

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88) ***PLEASE PRINT OR TYPE*** APPROVED OMB-0938-0008 FORM CMS-1500 (12-90), FORM RRB-1500, APPROVED OMB-1215-0055 FORM OWCP-1500, APPROVED OMB-0720-0001 (CHAMPUS)



PLEASE DO NOT STAPLE IN THIS AREA

[redacted]

°FQHC/RHC
°Periodic Screening
°Referral Indicator
°Immunizations

PICA

HEALTH INSURANCE CLAIM FORM

PICA

CARRIER

1. MEDICARE (Medicare #) MEDICAID (Medicaid #) CHAMPUS (Sponsor's SSN) CHAMPVA (VA File #) GROUP HEALTH PLAN (SSN or ID) FECA BLK LUNG (SSN) OTHER (ID)

1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1): 111111111X

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): Recipient, Joe

3. PATIENT'S BIRTH DATE MM DD YY: 10 15 2002 SEX M x F

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street): 111 Recipient Street

6. PATIENT RELATIONSHIP TO INSURED: Self Spouse Child Other

7. INSURED'S ADDRESS (No., Street)

CITY: Recipient Town STATE: NC

8. PATIENT STATUS: Single Married Other; Employed Full-Time Student Part-Time Student

CITY STATE

ZIP CODE: 12345 TELEPHONE (Include Area Code): (999)999-9999

ZIP CODE TELEPHONE (INCLUDE AREA CODE): ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (CURRENT OR PREVIOUS) YES NO

a. INSURED'S DATE OF BIRTH MM DD YY SEX M F

b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M F

b. AUTO ACCIDENT? PLACE (State) YES NO

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? YES NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO *If yes*, return to and complete item 9 a-d.

PATIENT AND INSURED INFORMATION

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED _____ DATE _____

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED _____

14. DATE OF CURRENT: MM DD YY ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY: 10 31 2003

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE

17a. I.D. NUMBER OF REFERRING PHYSICIAN

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)

1. V20.2
2. 460
3.
4.

22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

PHYSICIAN OR SUPPLIER INFORMATION

24 A DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
1 10 30 03	10 30 03	11		99392	EP		80 33	1	R			
2 10 30 03	10 30 03	11		90471	EP		13 71	1				
3 10 30 03	10 30 03	11		90472	EP		13 71	1				
4 10 30 03	10 30 03	11		90645			0 00	1				
5 10 30 03	10 30 03	11		90669			0 00	1				
6												

25. FEDERAL TAX I.D. NUMBER SSN EIN

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES NO

28. TOTAL CHARGE $ 107 75

29. AMOUNT PAID $

30. BALANCE DUE $ 107 75

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

Signature on File

SIGNED DATE 11/06/03

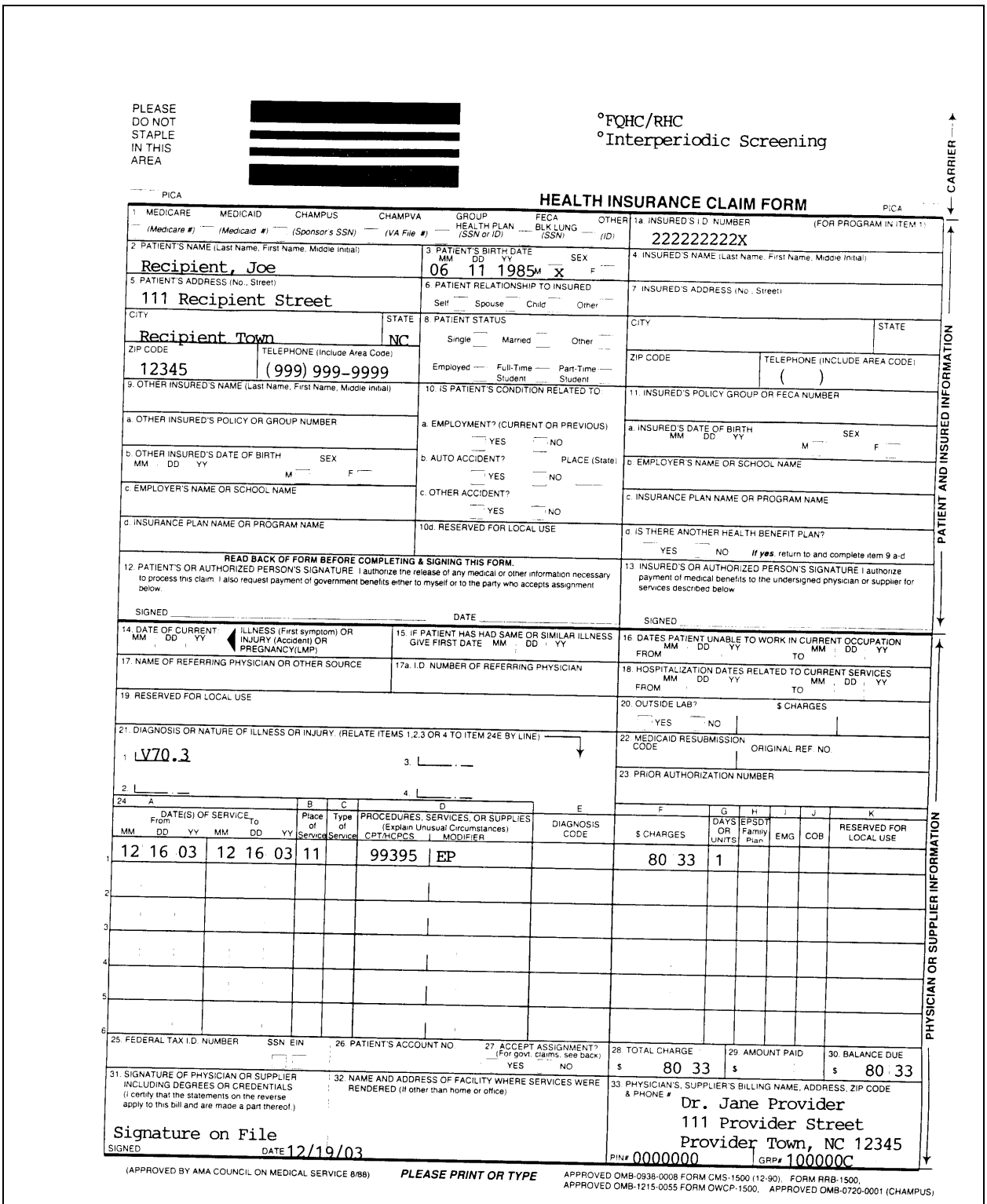
32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)

33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #

Dr. Jane Provider
111 Provider Street
Provider Town, NC 12345

PIN# 0000000 GRP# 100000C

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88) ***PLEASE PRINT OR TYPE*** APPROVED OMB-0938-0008 FORM CMS-1500 (12-90). FORM RRB-1500, APPROVED OMB-1215-0055 FORM OWCP-1500. APPROVED OMB-0720-0001 (CHAMPUS)



PLEASE DO NOT STAPLE IN THIS AREA

[redacted]

°FQHC/RHC
°Interperiodic Screening

PICA

HEALTH INSURANCE CLAIM FORM

PICA

CARRIER

1. MEDICARE (Medicare #) MEDICAID (Medicaid #) CHAMPUS (Sponsor's SSN) CHAMPVA (VA File #) GROUP HEALTH PLAN (SSN or ID) FECA BLK LUNG (SSN) OTHER (ID)

1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1): 222222222X

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): Recipient, Joe

3. PATIENT'S BIRTH DATE MM DD YY: 06 11 1985 SEX: M X F

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street): 111 Recipient Street

6. PATIENT RELATIONSHIP TO INSURED: Self Spouse Child Other

7. INSURED'S ADDRESS (No., Street)

CITY: Recipient Town STATE: NC

8. PATIENT STATUS: Single Married Other; Employed Full-Time Student Part-Time Student

CITY STATE

ZIP CODE: 12345 TELEPHONE (Include Area Code): (999) 999-9999

ZIP CODE TELEPHONE (INCLUDE AREA CODE): ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (CURRENT OR PREVIOUS) YES NO

a. INSURED'S DATE OF BIRTH MM DD YY SEX M F

b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M F

b. AUTO ACCIDENT? YES NO PLACE (State)

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? YES NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO *If yes*, return to and complete item 9 a-d

PATIENT AND INSURED INFORMATION

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED _____ DATE _____

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below

SIGNED _____

14. DATE OF CURRENT: MM DD YY ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE

17a. I.D. NUMBER OF REFERRING PHYSICIAN

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)

1. V70.3 3. _____

2. _____ 4. _____

22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24 A. DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B. Place of Service	C. Type of Service	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS CODE	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. EMG	J. COB	K. RESERVED FOR LOCAL USE
1 12 16 03	12 16 03	11		99395	EP		80 33	1				
2												
3												
4												
5												
6												

25. FEDERAL TAX I.D. NUMBER SSN EIN

26. PATIENT'S ACCOUNT NO

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES NO

28. TOTAL CHARGE $ 80 33

29. AMOUNT PAID $

30. BALANCE DUE $ 80 33

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

Signature on File

SIGNED DATE 12/19/03

32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)

33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #

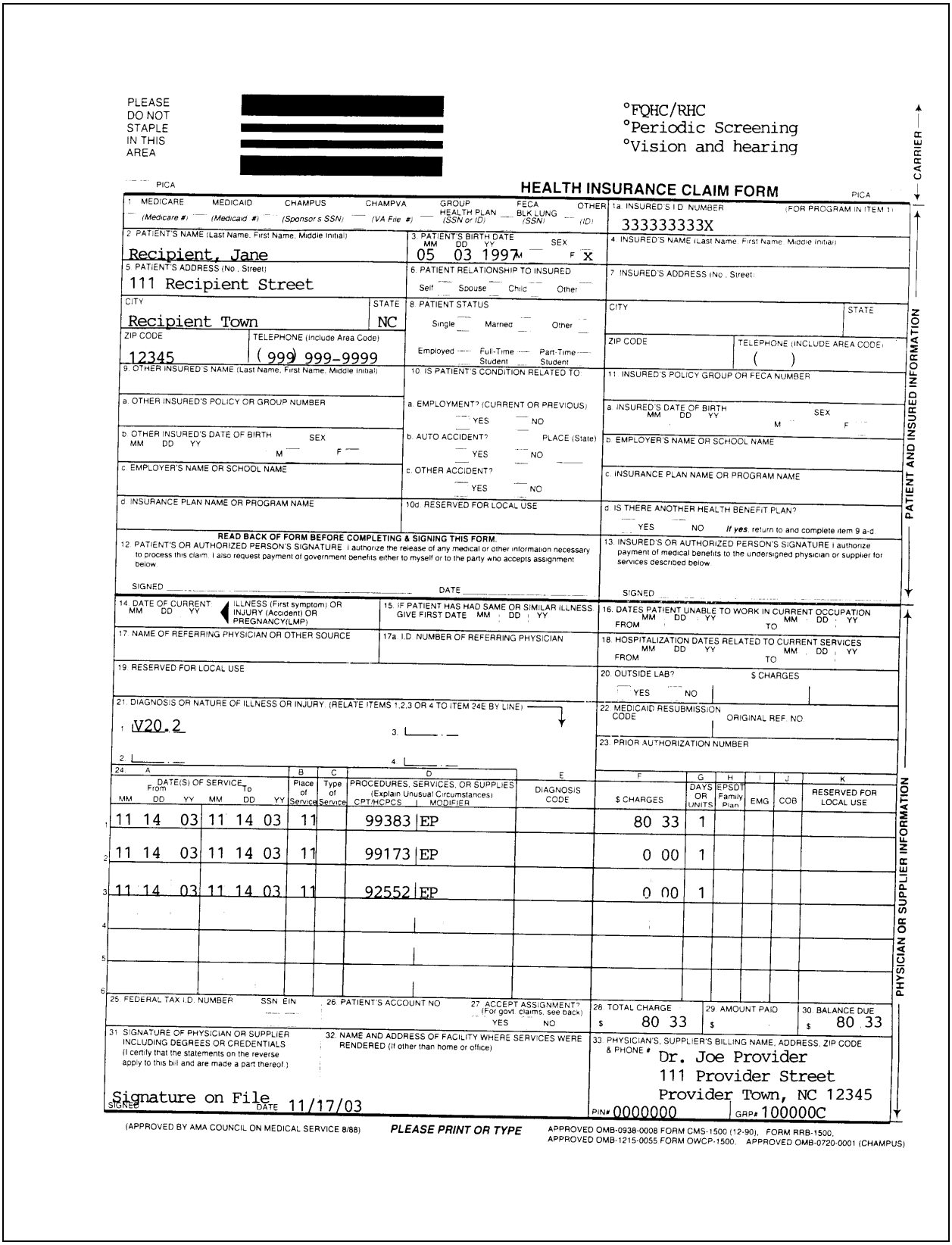
Dr. Jane Provider
111 Provider Street
Provider Town, NC 12345

PIN# 0000000 GRP# 100000C

PHYSICIAN OR SUPPLIER INFORMATION

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88) **PLEASE PRINT OR TYPE**

APPROVED OMB-0938-0008 FORM CMS-1500 (12-90), FORM RRB-1500, APPROVED OMB-1215-0055 FORM OWCP-1500, APPROVED OMB-0720-0001 (CHAMPUS)



PLEASE DO NOT STAPLE IN THIS AREA

[redacted]

°FQHC/RHC
°Periodic Screening
°Vision and hearing

PICA

HEALTH INSURANCE CLAIM FORM

PICA

CARRIER

1. MEDICARE ___ (Medicare #) MEDICAID ___ (Medicaid #) CHAMPUS ___ (Sponsor's SSN) CHAMPVA ___ (VA File #) GROUP HEALTH PLAN ___ (SSN or ID) FECA BLK LUNG ___ (SSN) OTHER ___ (ID)

1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1): 333333333X

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): Recipient, Jane

3. PATIENT'S BIRTH DATE MM DD YY: 05 03 1997 SEX M ___ F X

4. INSURED'S NAME (Last Name, First Name, Middle Initial):

5. PATIENT'S ADDRESS (No., Street): 111 Recipient Street

6. PATIENT RELATIONSHIP TO INSURED: Self ___ Spouse ___ Child ___ Other ___

7. INSURED'S ADDRESS (No., Street):

CITY: Recipient Town STATE: NC

8. PATIENT STATUS: Single ___ Married ___ Other ___ Employed ___ Full-Time Student ___ Part-Time Student ___

CITY: STATE:

ZIP CODE: 12345 TELEPHONE (Include Area Code): (999) 999-9999

ZIP CODE: TELEPHONE (INCLUDE AREA CODE): ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial):

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER:

a. OTHER INSURED'S POLICY OR GROUP NUMBER:

a. EMPLOYMENT? (CURRENT OR PREVIOUS) YES ___ NO ___

a. INSURED'S DATE OF BIRTH MM DD YY: SEX M ___ F ___

b. OTHER INSURED'S DATE OF BIRTH MM DD YY: SEX M ___ F ___

b. AUTO ACCIDENT? YES ___ NO ___ PLACE (State):

b. EMPLOYER'S NAME OR SCHOOL NAME:

c. EMPLOYER'S NAME OR SCHOOL NAME:

c. OTHER ACCIDENT? YES ___ NO ___

c. INSURANCE PLAN NAME OR PROGRAM NAME:

d. INSURANCE PLAN NAME OR PROGRAM NAME:

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES ___ NO ___ *If yes*, return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE. I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED _____ DATE _____

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE. I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED _____

PATIENT AND INSURED INFORMATION

14. DATE OF CURRENT: ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP) MM DD YY

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM ___ TO ___

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE

17a. I.D. NUMBER OF REFERRING PHYSICIAN

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM ___ TO ___

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES ___ NO ___ $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)

1. V20.2
2.
3.
4.

22. MEDICAID RESUBMISSION CODE: ORIGINAL REF. NO.:

23. PRIOR AUTHORIZATION NUMBER:

24. A DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
1 11 14 03	11 14 03	11		99383	EP		80 33	1				
2 11 14 03	11 14 03	11		99173	EP		0 00	1				
3 11 14 03	11 14 03	11		92552	EP		0 00	1				
4												
5												
6												

PHYSICIAN OR SUPPLIER INFORMATION

25. FEDERAL TAX I.D. NUMBER SSN EIN

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES ___ NO ___

28. TOTAL CHARGE: $ 80 33

29. AMOUNT PAID: $

30. BALANCE DUE: $ 80 33

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

Signature on File

SIGNED DATE 11/17/03

32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)

33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #

Dr. Joe Provider
111 Provider Street
Provider Town, NC 12345

PIN# 0000000 GRP# 100000C

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88) ***PLEASE PRINT OR TYPE*** APPROVED OMB-0938-0008 FORM CMS-1500 (12-90). FORM RRB-1500, APPROVED OMB-1215-0055 FORM OWCP-1500. APPROVED OMB-0720-0001 (CHAMPUS)

PLEASE DO NOT STAPLE IN THIS AREA

[redacted]

°FQHC/RHC
°Immunizations only

PICA

HEALTH INSURANCE CLAIM FORM

PICA

1. MEDICARE (Medicare #) MEDICAID (Medicaid #) CHAMPUS (Sponsor's SSN) CHAMPVA (VA File #) GROUP HEALTH PLAN (SSN or ID) FECA BLK LUNG (SSN) OTHER (ID)

1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1): 111111111X

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): Recipient, Joe

3. PATIENT'S BIRTH DATE MM DD YY: 05 29 2000 SEX M X F

4. INSURED'S NAME (Last Name, First Name, Middle Initial):

5. PATIENT'S ADDRESS (No., Street): 111 Recipient Street

6. PATIENT RELATIONSHIP TO INSURED: Self Spouse Child Other

7. INSURED'S ADDRESS (No., Street):

CITY: Recipient Town STATE: NC

8. PATIENT STATUS: Single Married Other; Employed Full-Time Student Part-Time Student

CITY STATE

ZIP CODE: 12345 TELEPHONE (Include Area Code): (999 999-9999

ZIP CODE TELEPHONE (INCLUDE AREA CODE): ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (CURRENT OR PREVIOUS) YES NO

a. INSURED'S DATE OF BIRTH MM DD YY SEX M F

b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M F

b. AUTO ACCIDENT? PLACE (State) YES NO

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? YES NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO *If yes*, return to and complete item 9 a-d

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED DATE

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED

14. DATE OF CURRENT: MM DD YY ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE

17a. I.D. NUMBER OF REFERRING PHYSICIAN

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM MM DD YY TO

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)

1. V04.0
2.
3.
4.

22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO

23. PRIOR AUTHORIZATION NUMBER

24 A. DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B. Place of Service	C. Type of Service	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS CODE	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. EMG	J. COB	K. RESERVED FOR LOCAL USE
1 10 20 03	10 20 03	11		90471	EP		13 71	1				
2 10 20 03	10 20 03	11		90472	EP		13 71	1				
3 10 20 03	10 20 03	11		90713			0 00	1				
4 10 20 03	10 20 03	11		90707			0 00	1				
5 10 20 03	10 20 03	11		90700			0 00	1				
6												

25. FEDERAL TAX I.D. NUMBER SSN EIN

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES NO

28. TOTAL CHARGE $ 27 42

29. AMOUNT PAID $

30. BALANCE DUE $ 27 42

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

Signature on File
SIGNED DATE 11/01/03

32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)

33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #

Dr. Jane Provider
111 Provider Street
Provider Town, NC 12345
PIN# 0000000 GRP# 100000C

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88) **PLEASE PRINT OR TYPE**

APPROVED OMB-0938-0008 FORM CMS-1500 (12-90). FORM RRB-1500, APPROVED OMB-1215-0055 FORM OWCP-1500. APPROVED OMB-0720-0001 (CHAMPUS)

PLEASE DO NOT STAPLE IN THIS AREA

[redacted]

°FQHC/RHC
°Core Visit
°Immunizations

PICA

HEALTH INSURANCE CLAIM FORM

PICA

1. MEDICARE (Medicare #) MEDICAID (Medicaid #) CHAMPUS (Sponsor's SSN) CHAMPVA (VA File #) GROUP HEALTH PLAN (SSN or ID) FECA BLK LUNG (SSN) OTHER (ID)

1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1): 222222222X

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): Recipient, Joe

3. PATIENT'S BIRTH DATE MM DD YY: 12 05 2001 SEX: M x F

4. INSURED'S NAME (Last Name, First Name, Middle Initial):

5. PATIENT'S ADDRESS (No., Street): 111 Recipient Street

6. PATIENT RELATIONSHIP TO INSURED: Self Spouse Child Other

7. INSURED'S ADDRESS (No., Street):

CITY: Recipient Town STATE: NC

8. PATIENT STATUS: Single Married Other; Employed Full-Time Student Part-Time Student

CITY: STATE:

ZIP CODE: 12345 TELEPHONE (Include Area Code): (999) 999-9999

ZIP CODE: TELEPHONE (INCLUDE AREA CODE): ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial):

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER:

a. OTHER INSURED'S POLICY OR GROUP NUMBER:

a. EMPLOYMENT? (CURRENT OR PREVIOUS) YES NO

a. INSURED'S DATE OF BIRTH MM DD YY SEX M F

b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M F

b. AUTO ACCIDENT? YES NO PLACE (State)

b. EMPLOYER'S NAME OR SCHOOL NAME:

c. EMPLOYER'S NAME OR SCHOOL NAME:

c. OTHER ACCIDENT? YES NO

c. INSURANCE PLAN NAME OR PROGRAM NAME:

d. INSURANCE PLAN NAME OR PROGRAM NAME:

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO *If yes*, return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED _____ DATE _____

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED _____

14. DATE OF CURRENT: MM DD YY ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE

17a. I.D. NUMBER OF REFERRING PHYSICIAN

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)

1. 382.9
2.
3.
4.

22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24 A DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
1 10 20 03	10 20 03	11		T1015			65 00	1				
2 10 20 03	10 20 03	11		90700			0 00	1				
3 10 20 03	10 20 03	11		90707			0 00	1				
4 10 20 03	10 20 03	11		90645			0 00	1				
5												
6												

25. FEDERAL TAX I.D. NUMBER SSN EIN

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES NO

28. TOTAL CHARGE $ 65 00

29. AMOUNT PAID $

30. BALANCE DUE $ 65 00

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

Signature on File

SIGNED DATE 10/25/03

32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)

33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #

Dr. Jane Provider
111 Provider Street
Provider Town,NC 12345

PIN# 0000000 GRP# 100000A

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88) **PLEASE PRINT OR TYPE**

APPROVED OMB-0938-0008 FORM CMS-1500 (12-90). FORM RRB-1500, APPROVED OMB-1215-0055 FORM OWCP-1500. APPROVED OMB-0720-0001 (CHAMPUS)

SCREEN ENTRY EXAMPLES OF THE SERVICES SCREEN (OPTION 65) FOR LOCAL HEALTH DEPARTMENTS THAT USE THE N.C. HEALTH SERVICES INFORMATION SYSTEM (HSIS)

Example #1 – Health Check Periodic Screening for a 1-month-old Child Receiving Two Immunizations.

```
NEXT RECORD:  COUNTY 999   SCREEN 65   ID 222222222   DATE 121002   ACTION A
MESSAGE:

NAME: Brown, Charlie                                DATE OF DIAB EVAL:______
SERVICE GROUP:
DIAG CODES A: V20.2 B:___.__ C:___.__ D:___.__ E: ___.__ F: ___.__ G:___.__
           H: ___.__                              HLTH CHK/EDSDT REFERRAL: _
 PHY ORDER DATE FOR AT: _______  OT: _____  PT: _____  SPL: _____
 B/
 R/            MODIFIERS DIAG     SVC              ATN   TYP  REF  POST
 D  PGM  CPT   M1 M2 M3  1 2 3 4  PROV  UNITS POS  PHY   SVC  PHY   OP   SITE
 B  CH  99381  EP __ __  A _ _ _  ROS__  01   71  _____  __  _____   _  99999
 R  CH  90744  __ __ __  A _ _ _  ROS__  01   71  _____  __  _____   _  99999
 R  CH  90700  __ __ __  A _ _ _  ROS__  01   71  _____  __  _____   _  99999
```

Example #2 – Health Check Periodic Screening for an 18-Year-Old with an Additional Procedure, Plus Vision and Hearing Screenings. Diagnosis warrants a referral for a follow-up visit, designated with "R" entered in the HLTH CHK/EPSDT REFERRAL data field.

```
NEXT RECORD:  COUNTY 999    SCREEN 65    ID 333333333   DATE 120902  ACTION A
MESSAGE:

NAME: Patty, Peppermint                             DATE OF DIAB EVAL:______
SERVICE GROUP:
DIAG CODES A: V20.2 B: 460.__ C:___.__ D:___.__ E: ___.__ F: ___.__ G:___.___
           H: ___.__                              HLTH CHK/EDSDT REFERRAL: R
 PHY ORDER DATE FOR AT: _______  OT: _____  PT: _____  SPL: _____
 B/
 R/            MODIFIERS DIAG     SVC              ATN   TYP  REF  POST
 D  PGM  CPT   M1 M2 M3  1 2 3 4  PROV  UNITS POS  PHY   SVC  PHY   OP   SITE
 B  CH  99385  EP __ __  A _ _ _  ROS__  01   71  _____  __  _____   _   99999
 B  CH  87081  __ __ __  B _ _ _  ROS__  01   71  _____  __  _____   _   99999
 R  CH  99173  __ __ __  A _ _ _  ROS__  01   71  _____  __  _____   _   99999
 R  CH  92551  __ __ __  A _ _ _  ROS__  01   71  _____  __  _____   _   99999
```

N.C. Health Services Information System Screen Examples, continued

Example #3 – Health Check Interperiodic Screening for a 4-Year-Old Child Receiving Two Immunizations.

```
NEXT RECORD:  COUNTY 999   SCREEN 65    ID 444444444    DATE 120902  ACTION A
MESSAGE:

NAME: Smith, Barbie                                  DATE OF DIAB EVAL: ______
SERVICE GROUP:
DIAG CODES A: V70.3_ B:___.__ C:___.__ D:___.__ E: ___.__ F: ___.__ G:___.__
           H: ___.__                                 HLTH CHK/EDSDT REFERRAL: _
 PHY ORDER DATE FOR AT: _______  OT: _____  PT: _____  SPL: _____
 B/
 R/            MODIFIERS DIAG     SVC              ATN   TYP  REF  POST
 D  PGM  CPT   M1 M2 M3  1 2 3 4  PROV  UNITS POS  PHY   SVC  PHY   OP   SITE
 B  CH  99382  EP __ __  A _ _ _  ROS__  01   71  _____  __  _____  _   99999
 R  CH  90645  __ __ __  A _ _ _  ROS__  01   71  _____  __  _____  _   99999
 R  CH  90658  __ __ __  A _ _ _  ROS__  01   71  _____  __  _____  _   99999
```

Example #4 – Health Check Periodic Screening and Immunizations for Child Age 1 with Referral/Follow-up Indicator. Diagnosis warrants a referral for a follow-up visit, designated with "R" entered in the HLTHCHK/EPSDT REFERRAL data field.

```
NEXT RECORD:  COUNTY 999   SCREEN 65   ID 444444444    DATE 120902  ACTION A
MESSAGE:

NAME:  Robin, Christopher                            DATE OF DIAB EVAL: ______
SERVICE GROUP:
DIAG CODES A: V20.2_ B:460.__ C:___.__ D:___.__ E: ___.__ F: ___.__ G:___.__
           H: ___.__                                 HLTH CHK/EDSDT REFERRAL: R
 PHY ORDER DATE FOR AT: _______  OT: _____  PT: _____  SPL: _____
 B/
 R/            MODIFIERS DIAG     SVC              ATN   TYP  REF  POST
 D  PGM  CPT   M1 M2 M3  1 2 3 4  PROV  UNITS POS  PHY   SVC  PHY   OP   SITE
 B  CH  99392  EP __ __  A _ _ _  ROS__  01   71  _____  __  _____  _   99999
 R  CH  90645  __ __ __  A _ _ _  ROS__  01   71  _____  __  _____  _   99999
 R  CH  90669  __ __ __  A _ _ _  ROS__  01   71  _____  __  _____  _   99999
```

N.C. Health Services Information System Screen Examples, continued

Example #5 – Immunization Administration Fee ONLY for Child Age 3.

```
NEXT RECORD:  COUNTY 999   SCREEN 65   ID 555555555    DATE 112202   ACTION A
MESSAGE

NAME: Barkley, Charles                              DATE OF DIAB EVAL: _______
SERVICE GROUP:
DIAG CODES A: V06.8_B:___.__ C:___.__ D:___.__ E: ___.__ F: ___.__ G:___.__
           H: ___.__                                HLTH CHK/EDSDT REFERRAL: __
 PHY ORDER DATE FOR AT: _______  OT: ______  PT: ______  SPL: ______
 B/
 R/            MODIFIERS DIAG     SVC              ATN   TYP  REF  POST
 D  PGM  CPT   M1 M2 M3  1 2 3 4  PROV  UNITS POS  PHY   SVC  PHY   OP   SITE
 B  IM  90471  EP __ __  A _ _ _  NURSE  01   71  ______  __  ______  _   99999
 R  IM  90700  __ __ __  A _ _ _  NURSE  01   71  ______  __  ______  _   99999
 R  IM  90713  __ __ __  A _ _ _  NURSE  01   71  ______  __  ______  _   99999
 R  IM  90744  __ __ __  A _ _ _  NURSE  01   71  ______  __  ______  _   99999
 R  IM  90647  __ __ __  A _ _ _  NURSE  01   71  ______  __  ______  _   99999
```

Example #6 – Office Visit with One Immunization for a Child Age 2.

```
NEXT RECORD:  COUNTY 999   SCREEN 65   ID 666666666    DATE 111402   ACTION A
MESSAGE

NAME: Smith, Hercules                               DATE OF DIAB EVAL:_______
SERVICE GROUP:                                                 THRU DT: _______
DIAG CODES A: 382.9_  B:___.__ C:___.__ D:___.__ E: ___.__ F: ___.__ G:___.__
           H: ___.__                                HLTH CHK/EDSDT REFERRAL: _
 PHY ORDER DATE FOR AT: _______  OT: ______  PT: ______  SPL: ______
 B/
 R/            MODIFIERS DIAG     SVC              ATN   TYP  REF  POST
 D  PGM  CPT   M1 M2 M3  1 2 3 4  PROV  UNITS POS  PHY   SVC  PHY   OP   SITE
 B  CH  99212  __ __ __  A _ _ _  PHY    01   71  ______  __  ______  _   99999
 B  CH  90471  EP __ __  A _ _ _  NURSE  01   71  ______  __  ______  _   99999
 R  CH  90716  __ __ __  A _ _ _  NURSE  01   71  ______  __  ______  _   99999
```

TIPS FOR DECREASING DENIALS

EOB	Message	Tip
010	Diagnosis or service invalid for recipient age. Verify MID, diagnosis, procedure code or procedure code/modifier combination for errors. Correct and submit as a new claim.	Verify the recipient's Medicaid identification (MID) number, DOB, diagnosis, and procedure codes. Make corrections, if necessary, and resubmit to EDS as a new claim. If all information is correct, send the claim and RA to the DMA Claims Analysis Unit, 2519 Mail Service Center, Raleigh, NC 27699-2519.
060	Not in accordance with medical policy guidelines.	Verify that only one vision and/or hearing screening is billed per date of service. Make corrections and resubmit as a new day claim.
082	Service is not consistent with/or not covered for this diagnosis/or description does not match diagnosis.	Verify diagnosis code is V20.2 or V70.3 for the Health Check screening according to the billing guidelines on page 9. Correct claim and resubmit.
349	Health Check screening and related service not allowed same day, same provider or member of same group. Resubmit as an adjustment with documentation supporting related services.	Verify if related services billed on same or different claim as the Health Check screening are Health Check components. Health Check screening and related services will not be paid for same date of service initially. Resubmit as an adjustment with medical documentation supporting the need for related services.
685	Health Check services are for Medicaid recipients birth through age 20 only.	Verify recipient's age. Only recipients age birth through 20 years of age are eligible for Health Check program services.
1036	Thank you for reporting vaccines. This vaccine was provided at no charge through VFC Program. No payment allowed.	Immunizations(s) are available at no charge through the UCVDP/VFC Program.
1058	The only well child exam billable through the Medicaid program is a Health Check screening. For information about billing Health Check, please call 1-800-688-6696.	Bill periodic screening with V20.2 and interperiodic screenings with V70.3. Check the preventive medicine code entered in block 24D of the claim form.
1422	Immunization administration not allowed without the appropriate immunization. Refer to the most recent Health Check special bulletin.	Check the claim to ensure that the immunization procedure code(s) are billed on the same claim as the immunization administration code(s). Make corrections and resubmit as a new day claim.

Tips For Decreasing Denials, continued

EOB	Message	Tip
1769	No additional payment made for vision and/or hearing services.	Payment is included in Health Check reimbursement.
1770	Invalid procedure/modifier/diagnosis code combination for Health Check or Family Planning services. Correct and resubmit as a new claim.	Health Check services must be billed with the diagnosis code V20.2 or V70.3 and the EP modifier. Verify the correct diagnosis code, procedure code and modifier for the service rendered. Family planning services must be billed with the FP modifier and the diagnosis code V250.9.
1771	All components were not rendered for this Health Check screening.	For periodic screenings, verify all required components, such as vision and or hearing assessments were performed and reported on the claim form using the EP modifier. Make corrections and resubmit as a new day claim.

HEALTH CHECK BILLING WORKSHEET

The Health Check Billing Worksheet (see page 40) may be used in your practice to facilitate Health Check billing.

For additional billing questions please contact EDS at 1-800-688-6696 or 919-851-8888.

HEALTH CHECK BILLING WORKSHEET

Date of Service _____

Patient's Name	Next Screening Date (optional)
Medicaid ID number	Date of Birth

Health Check Diagnosis Code		
Periodic Health Check Screening	Periodic Health Check Screening V20.2	
Interperiodic Health Check Screening	Interperiodic Health Check Screening V70.3	

Health Check Screening Code			
Description	**Preventive Medicine Codes**	**Diagnosis Code**	✓
Regular Periodic Screening - Birth through 20 years Vision Assessment based on age Hearing Assessment based on age	99381-9985; 99391-99395 With EP Modifier Vision Assessment CPT Code 99172 or 99173 With EP Modifier Hearing Assessment CPT Code 92551or 92552 With EP Modifier	V20.2	
Interperiodic Screening - Birth through 20 years	99381-9985; 99391-99395 With EP Modifier	V70.3	

Second Diagnosis _____ (if applicable)		
Description	**Indicator**	✓
Follow-up with screening provider or another provider	R	

Third Diagnosis _____ (if applicable)		
Description	**Indicator**	✓
Follow-up with screening provider or another provider	R	

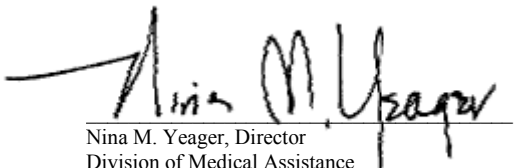
Fourth Diagnosis _____ (if applicable)		
Description	**Indicator**	✓
Follow-up with screening provider or another provider	R	

Description	**CPT Codes**	**Unit**	
Immunization Administration Fee	90471 EP Modifier	One immunization	
Additional Immunization Administration Fee	90472 EP Modifier	Additional immunizations	

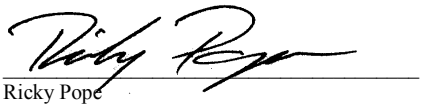
IMMUNIZATION BILLING WORKSHEET*

Code	Description	Diagnosis	VFC
90281	Immune Globulin	V07.2	
90371	Hepatitis B Immune Globulin	V07.2	
90375	Rabies Immune Globulin	V07.2	
90376	Rabies Immune Globulin – Heat treated (RIG-HT)	V07.2	
90384	Rho (D) Immune Globulin Full Dose	V07.2	
90385	Rho (D) Immune Globulin Mini Dose	V07.2	
90389	Tetanus Immune Globulin	V07.2	
90396	Varicella-Zoster Immune Globulin	V07.2	
90585	BCG	V03.2	
90632	Hepatitis A Vaccine – Age 18 & up	V05.8	
90633	Hepatitis A Vaccine – 2 dose Age 2 & up	V05.8	
90645	Hib Titer – 4 dose	V03.8 or V05.8	VFC 2 mo – 5 yrs
90647	Hib – 3 dose (Brand name – PedVax)	V03.8 or V05.8	VFC 2 mo – 5 yrs
90648	Hib – 4 dose (Brand name – ActHib)	V03.8 or V05.8	VFC 2 mo – 5 yrs
90657	Influenza Split Virus (6-35 months of age)	V04.8	VFC 6 mo – 35 mo
90658	Influenza Split Virus (3 years and above)	V04.8	VFC 3 yrs – 18 yrs
90669	Pneumococcal PCV7 (2-59 months)	V03.82 or V05.8	VFC 2 mo – 59 mo
90675	Rabies Vaccine – IM	V04.5	
90700	DTaP	V06.8	VFC 2 mo – 7 yrs
90702	DT – Age under 9	V06.8	VFC 2 mo – 6 yrs
90703	Tetanus Toxoid	V03.7	
90704	Mumps	V04.6	
90705	Measles	V04.2	
90706	Rubella	V04.3	
90707	MMR	V06.4	VFC 12 mo – 18 yrs
90713	IPV (Injectable Polio Vaccine)	V04.0	VFC 2 mo – 18 yrs
90716	Varicella	V05.4	VFC 12 mo – 18 yrs
90718	Td	V06.5	VFC 7 yrs – 18 yrs
90721	DTaP/Hib	V06.8	
90732	Pneumococcal PPV23 (High Risk Only)	V03.82 or V05.8	VFC 2 yrs – 18 yrs
90733	Meningococcal	V03.89	
90744	Hepatitis B Vaccine – Pediatric/adol -3 dose	V05.8	VFC 0 – 18 yrs
90746	Hepatitis B Vaccine – Age 19 and above	V05.8	
90747	Hepatitis B Vaccine - Dialysis Pt./immunosuppressed -4 dose	585	

Note: This list is subject to change.



Nina M. Yeager, Director
Division of Medical Assistance
Department of Health and Human Services



Ricky Pope
Executive Director
EDS

e

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